Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 31, 2019	2019_661683_0013	015843-18, 025139-18, 006765-19	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

Long-Term Care Home/Foyer de soins de longue durée

Douglas H. Rapelje Lodge
277 Plymouth Road WELLAND ON L3B 6E3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LISA BOS (683), AILEEN GRABA (682), STACEY GUTHRIE (750)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 3, 4, 5, 8, 9, 10, 11, 12, 15, 16 and 18, 2019.

This inspection was completed concurrently with complaint inspection #2019_661683_0012.

The following intakes were completed during this critical incident inspection:
Log #015843-18, CIS #M604-000019-18 - related to the prevention of abuse and neglect and responsive behaviours
Log #025139-18, CIS #M604-000026-18 - related to the prevention of abuse and neglect and responsive behaviours
Log #006765-19, CIS #M604-000003-19 - related to personal support services.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), Associate Director of Resident Care (ADRC), the Clinical Documentation and Information (CDI) lead, the Registered Dietitian (RD), registered staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed the complaints log and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that personal support worker (PSW) #116 used safe positioning devices or techniques when assisting resident #011.

CI log #006765-19 / M604-000003-19 was submitted to the Director on an identified date, which indicated that an incident occurred with PSW #116 and resident #011 where the resident sustained an identified injury.

A review of resident #011's clinical record indicated that they had an identified cognitive status at the time of the incident. A progress note from an identified date indicated that PSW #116 was assisting resident #011 in an identified manner when they sustained the identified injury. The progress note indicated that an identified intervention was not in place at the time of the incident for an identified reason.

A review of a specific policy indicated guidelines for staff when assisting residents in an identified manner.

During an interview on an identified date, resident #011 stated that the identified intervention was not in place for an identified reason at the time of the injury. During an interview on an identified date, PSW #116 stated the resident's preference for the identified intervention and indicated that the identified intervention was not in place at the time of the injury. During an interview on an identified date, RPN #117 and RN #118 stated that if the identified intervention was not in place for an identified reason, staff were to respond in a specific manner. RPN #117 and RN #118 confirmed that PSW #116 did not use safe positioning techniques when assisting resident #011 on the identified date. During an interview on an identified date, the Associate Director of Resident Care (ADRC) confirmed that PSW #116 did not use safe positioning techniques when assisting resident #011 on the identified date, which contributed to the injury. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe positioning devices or techniques while assisting residents, to be implemented voluntarily.

Issued on this 31st day of July, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.