Ontario

Inspection Report Under the

Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 17, 2024	
Original Report Issue Date: December 8, 2023	
Inspection Number: 2023-1599-0003 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: The Regional Municipality of Niagara	
Long Term Care Home and City: Douglas H. Rapelje Lodge, Welland	
Amended By Erika Reaman (000764)	**Inspector who Amended Digital Signature** Erika Reaman (000764)

AMENDED INSPECTION SUMMARY

This report has been amended to: NC #004 has been rescinded.

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Lead Inspector Erika Reaman (000764)	**Additional Inspector(s)** Adiilah Heenaye (740741)
Amended By Erika Reaman (000764)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 25, 26, 27, 30, 31, 2023 and November 1, 2, 3, 6, 7, 8, 9, 2023

The following intake(s) were inspected:

- Intake: #00093374 -- Complainant/Resident with concerns regarding home addressing solution related to post-inspection.
- Intake: #00096374 Critical Incident (CI) #M604-000019-23 – Falls Prevention and Management.
- Intake: #00096530 Complainant with concerns for resident regarding falls prevention and management, pain management and resident care and support services.
- Intake: #00097044 CI #M604-000022-23 – Falls Prevention and Management.
- Intake: #00097188 CI #M604-000024-23 – Falls Prevention and Management.
- Intake: #00097543 CI#M604-000025-23 – Falls Prevention and Management.

The following **Inspection Protocols** were used during this inspection:

Continence Care
Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Pain Management
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A. A resident fell when they were attempting to self-transfer. The plan of care indicated to not leave the resident unattended.

A staff first responded to the resident after the fall. Staff confirmed that the resident was left unattended by staff.

Sources: Interview with resident, interview with staff; Review of resident's clinical records. [740741]

B. The resident was assessed by an occupational therapist on a date, and the resident was prescribed a type of equipment. The home met with the resident along with occupational therapist on a date, to review the use of the equipment and necessary adjustments were completed. The Resident agreed to adjustments made to the equipment.

The administrator stated that the resident's care needs changed multiple times, when staff notified management about the resident's related safety risks.

The home initially arranged for assessment by clinical consultant on a date in 2022. On a date in January 2023, the administrator reached out to clinical consultant as the resident had a change in their care needs. In January 2023, staff clinical consultant recommended that the home should consider using the equipment's features and to have an occupational therapist further assess the resident using the equipment.

The administrator confirmed that the home did not follow through with the plan of care from clinical consultant in January 2023, that is to have an occupational therapist assess the resident when the resident's status changed.

Sources: Interview with staff; Review of resident's clinical records. [740741]

C. A resident's plan of care indicated that they required a total assistance of two staff for transfers and repositioning. Staff written documentation indicated that they moved the resident in bed during their shift. Staff confirmed in an interview that they repositioned the resident independently during their shift.

Failure to ensure that care was provided as set out in the plan of care for the resident led to an increased risk of harm to resident's safety.

Sources: Resident's clinical records, Staff written documentation, interview with staff. [000764]

D. A resident's plan of care indicated that they were to use a specific surface between their knees for positioning while in bed for comfort. Staff written documentation indicated they did not use the specific surface, as per the plan of care, and they reported that they did not like using this for positioning the resident.

Failure to ensure that the resident was positioned in bed as specified in their plan of care led to an increased risk of discomfort for resident.

Sources
Resident's clinical records, Staff written documentation of fall, interview with staff. [000764]

E. A resident's plan of care included special instructions directing night staff that the SDM was to be notified of any falls or concerns. This resident had a fall and the post fall assessment, indicated for the SDM to be called by day staff regarding fall. Staff indicated that these special instructions were in their care plan at time of the fall, and that an additional order was added after as an additional reminder for staff.

Sources
Complainants emails, resident's clinical records, interview with staff. [000764]

WRITTEN NOTIFICATION: Plan of Care: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to document plan of care as set out in the plan of care for a resident.

Rationale and Summary

A. The Ministry of Long-Term Care (MLTC) received concerns from a resident that the home's staff did not monitor their skin.

Point of Care (POC) documentation related to observations of changes in health condition/monitoring changes in skin integrity for the resident indicated that documentation was missing on several occasions.

Staff did not document the monitoring of skin integrity as set out in the plan of care.

Sources: Clinical records for resident; Interview with staff. [740741]

B. A resident's plan of care indicated that they were to receive a partial sponge bath every morning and every evening. A concern was brought forward on a specific date. A lookback report for the specific date showed no documentation for the partial sponge bath provided for the morning or evening. Staff confirmed that there was no documentation for the resident's partial sponge bath in the morning or evening on specific date mentioned.

Sources
Resident's clinical records, interview with staff. [000764]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed.

Rationale and Summary

A resident's Substitute Decision Maker (SDM) had email communication with the home requesting that resident not be positioned in a certain way due to discomfort. Staff acknowledged that the plan of care was not revised after this discussion to reflect this change.

Failure to ensure that a resident's plan of care was revised when their care needs changed put the resident at risk for discomfort.

Sources
Review of resident clinical records, complainant emails sent to inspector, interview with staff. [000764]

(A1)
The following non-compliance(s) has been amended: NC #004

WRITTEN NOTIFICATION: Therapy Services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22s. 65 (b)
Therapy services. 65 (b) occupational therapy and speech-language therapy.