Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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Original Public Report

Report Issue Date: October 9, 2024
Inspection Number: 2024-1599-0003
Inspection Type: Complaint Critical Incident
Licensee: The Regional Municipality of Niagara
Long Term Care Home and City: Douglas H. Rapelje Lodge, Welland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29-30, 2024, September 3-6, September 9-13, and September 16-19, 2024.

The following intake(s) were inspected:

- Intake: #00119381- Complaint with concerns related to resident care and support services.
- Intake: #00121668 - Complaint with concerns related to resident care and support services, skin and wound management, and medication management.
- Intake: #00122304/Critical Incident (CI) #M604-000011-24 - related to infection prevention and control.
- Intake: #00124228/CI #M604-000012-24 - related to falls prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Medication Management
Infection Prevention and Control
Falls Prevention and Management

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)
Plan of care
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 care was provided to a resident as specified in their plan of care.

Rationale and Summary
A resident sustained a fall that resulted in an injury requiring the use of an intervention. Initially the intervention was to be in place at all times. The resident was receiving follow up care following the fall and received an order on a date to wean them off of the intervention. Review of the resident's clinical records did not show the implementation of weaning from the intervention until a later date.

A staff member acknowledged that there was a delay in weaning the intervention for the resident due to staffing changes.

Failure of the home to provide care to the resident as specified in their plan of care led to prolonged treatment that may not have been necessary.

Sources: a resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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 care plan was revised when their care needs changed.

Rationale and Summary
A resident had an unwitnessed fall that resulted in an injury.

The resident's plan of care indicated that they required the use of falls interventions when sleeping in bed. A staff member indicated that the resident's sleeping patterns had changed and that they no longer preferred to sleep in bed.

The Falls Lead and the Associate Director of Care (ADOC) indicated they were not aware that the resident was not sleeping in bed and acknowledged that a falls prevention intervention should have been added to where the resident preferred to sleep.

Failure to update the resident's plan of care when their care needs changed led to risk of resident safety.

Sources: Resident clinical records, interview with staff, the Falls Lead and the ADOC.

WRITTEN NOTIFICATION: Medication Management System

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to comply with the home's medication management system for a resident.

In accordance with O. Reg. 245/22, s. 11 (1) (b), the licensee is required to ensure that there is a medication management program and its policies must be complied with.

Specifically, staff did not comply with the policy "Oxygen Therapy", revised February 9, 2024, which was included in the licensee's medication and management program.

Rationale and Summary
A resident required the use of oxygen therapy on a specified date. The home's policy titled "Oxygen Therapy" indicated if a resident continued to require oxygen after initial application, an order must be obtained from the physician/nurse practitioner (MD/NP). The home's policy also indicated that a referral was to be completed immediately upon initiation of oxygen use. Further review of the resident's clinical records showed a referral for oxygen therapy was not completed until a later date.

A staff member confirmed that the resident did not receive an order for continued oxygen use. Staff also confirmed that the home's policy was not followed when the referral for oxygen therapy was not completed as required.

Failure to follow the home's policy related to oxygen therapy, put the resident at risk for potential health complications, and not having required assessments completed as required.

Sources: Resident clinical records, interview with staff, home's policy titled "Oxygen Therapy", revised February 9, 2024.

WRITTEN NOTIFICATION: Based on assessment of resident

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that care set out in the plan of care was based on an assessment and on the needs and preferences of a resident.

Rationale and Summary
A concern brought forward to the Ministry of Long-Term Care (MLTC) indicated a resident had received an intervention following a fall and that when the resident was admitted to the home it had been documented that the they were not to have that specific intervention.

An assessment, completed when the resident was admitted, indicated not to use the specific intervention. Records indicated that the intervention was implemented

into the resident's plan of care when they were admitted to the home.

The resident stated when they were admitted their Power of Attorney (POA) had instructed the home not to use the specific intervention. They also stated that on admission it was their preference not to use the intervention.

The resident's preferences were not implemented into their plan of care when they were admitted to the home.

Sources: Resident plan of care; interviews with resident and the complainant.

WRITTEN NOTIFICATION: Integration of assessments, care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborate with each other in the development and implementation of their plan of care.

Rationale and Summary
A report was received by the home from an external consultation for a resident. The plan in the report instructed the home to monitor the resident's bloodwork for a specified timeframe.

A review of the resident's plan of care showed no documentation that the blood work was ordered until a later date, when staff were made aware.

A staff member acknowledged that the bloodwork order from the external consultation was not integrated into the resident's plan of care at the time it was ordered.

There was risk that the resident would not have received the required blood work when the order was not completed until staff were made aware.

Sources: Resident plan of care; external consultation report; interview with staff.

WRITTEN NOTIFICATION: General requirements

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions, and the resident's responses to interventions were documented.

Rationale and Summary
A report indicated that a resident's blood level was abnormal on a specified date. Documentation indicated that the level was treated and a medication was put on hold until the blood level was reassessed. The resident's blood level was

reassessed at a later date and a report indicated their blood level was also abnormal.

A review of the resident's clinical record showed no documentation of the physician’s reassessment and what action was to be taken to manage the blood level or whether the medication would be restarted or not.

A staff member confirmed there was no documentation of the reassessment or the plan moving forward related to the medication or treatment of the blood level.

There was risk for a gap in the resident's care related to the treatment of their blood level and their medication management when the physician's reassessment was not documented.

Sources: Resident plan of care; blood level reports; interview with staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents’ drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the Falls Prevention and Management program for a resident.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure that a Falls Prevention and Management Program is developed and implemented in the home to reduce the incidence of falls and the risk of injury, and must be complied with.

Specifically, staff did not comply with the policy titled "Head Injury Routine (HIR) & Neurological Assessment", revised August 19, 2024, which was included in the home's Fall Prevention and Management program.

Rationale and Summary
A resident had an unwitnessed fall that resulted in an injury. The MD/NP was not notified immediately of the injury. According to the home's policy titled "Head Injury Routine (HIR) & Neurological Assessment" registered staff are to notify the MD/NP immediately if injury is suspected.

A staff member indicated that they did not notify the MD/NP on their shift of the resident's injuries, and stated that day staff are usually the ones to notify the MD/NP of falls with injuries unless it is an emergency.

Failure to notify the physician immediately of a resident's injury following a fall, put the resident at risk for potential complications from their injury.

Sources: Resident clinical records, home's policy titled "Head Injury Routine (HIR) & Neurological Assessment, revised August 19, 2024, interview with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident that was exhibiting altered skin integrity received a skin assessment.

Rationale and Summary
A resident experienced a fall that resulted in an injury. The resident's clinical records showed no skin assessment completed for one of the injuries that the resident sustained.

A staff member confirmed that a skin assessment was not completed and acknowledged that one should have been done.

Not completing a skin assessment of the injury posed a risk of not properly assessing an altered skin integrity.

Sources: Resident clinical records, interview with staff.