Ontario

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

# Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*


**Ministry of Health and Long-Term Care**
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**
Division de la responsabilisation et de la performance du système de santé
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| Date(s) of inspection/Date de l'inspection | Inspection No/ d'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| April 17,18,19,20, 2012 | 2012_067171_0011 | Complaint – H-002360-11<br>H-002371-11 |

**Licensee/Titulaire**

The Regional Municipality of Niagara, 2201 St. David's Road, 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(s)**

Elisa Wilson 171

## Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Complaint Inspection.

During the course of the inspection, the inspector spoke with the administrator, registered staff, health care aides and residents.

During the course of the inspection, the inspector toured the home, had workers demonstrate the chair alarm system and call response system, reviewed the plans of care of identified residents and reviewed specific home policies.

The following Inspection Protocols were used:
Falls Prevention

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
2 VPC

## NON- COMPLIANCE / (Non-respectés)

**Definitions/Définitions**

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

| | |
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| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.<br><br>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.) | Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.<br><br>Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi. |

**WN #1: The licensee has failed to comply with O. Reg. 79/10, s.17. Communication and response system.**

**Specifically failed to comply with the following subsections:**

**s. 17(1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**a) can be easily seen, accessed and used by residents, staff and visitors at all times;**

**Findings:**

1. The licensee had not ensured that the resident-staff communication and response system was easily seen and accessed by residents at all times.

A resident was observed sitting in a wheelchair in the bedroom near the end of the bed. The wheelchair foot rest was caught on the bedside table and the resident was unable to move the chair or the table. The call bell was on the floor next to the head of the bed and out of reach. The call bell was tested and did not activate when pressed. Staff indicated the resident had another call bell the resident usually had nearby however it was not with the resident at that time. A health care aide confirmed the call bell attached to the wall was not in working order and the other call bell was not with the resident.

**Additional Required Action:**

**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 the resident-staff communication and response system is easily seen and accessed by residents at all times, to be implemented voluntarily.

**WN #2: The licensee has failed to comply with O. Reg. 79/10, s. 30. General requirements.**

**Specifically failed to comply with the following subsections:**

**s. 30(1) Every licensee of a long-tem care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**

**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of resident to specialized resources where required.**

**Findings:**

1. The licensee had not ensured that the Falls Prevention Program had a written description of the program including goals and objectives, relevant policies, procedures and protocols, methods to reduce risk, methods to monitor outcomes and protocols for referral of resident to specialized resources.

The administrator confirmed the home had a draft falls prevention program started however it had not been implemented in the home at the time of this inspection.

**Additional Required Action:**

**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 the home has a written description of the Falls Prevention Program, to be implemented voluntarily.

**WN #3: The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6. Plan of Care.**

**Specifically failed to comply with the following subsections:**

**s. 6(1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(c) clear directions to staff and others who provide direct care to the resident**

**s. 6(10) Every 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**

**Findings:**

1. The licensee had not ensured the written plan of care set out clear direction to staff who provide care to the resident.
A resident's plan of care, in the Risk of Falls section, indicated specific call bell procedures and equipment to be used, however the information was vague. Different staff members understood the instructions in different ways. It was unclear in the written plan of care if and when the resident should have this particular call bell system in place.

2. The licensee had not ensured the plan of care was reviewed and revised when the resident's care needs changed.
The physician discontinued the use of a specific restraint as per the physician's written orders for an identified resident. This change was also documented in the progress notes. The mobility care plans completed since that time still indicated a restraint was in use. The administrator confirmed this restraint was not being used after it was discontinued by the physician and that the plan of care was not updated when the change was made.

| Signature of Licensee or Representative of Licensee<br>Signature du Titulaire du représentant désigné | Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.<br>Elisa Wilson |
|---|---|
| Title: Date: | Date of Report: (if different from date(s) of inspection).<br>May 8, 2012 |