Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 30, 2017	2017_323130_0019	010801-17	Resident Quality Inspection

Licensee/Titulaire de permis

FOYER RICHELIEU WELLAND
655 Tanguay Ave WELLAND ON L3B 6A1

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

FOYER RICHELIEU WELLAND
655 TANGUAY AVENUE WELLAND ON L3B 6A1

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

GILLIAN TRACEY (130), KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 16, 19, 20, 21, 22, 23, 25, 26, 2017.

During this inspection, the home was toured, care was observed, residents and staff were interviewed, clinical records and relevant policies and procedures were reviewed.

During the course of the inspection, the inspector(s) spoke with the Chief Administrative Officer, Chief Financial Officer, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Food Services Supervisor (FFS), Registered staff, Personal Support Workers (PSWs), recreation staff, President of the Residents' Council Designate, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) On an identified date in 2017, an assessment completed by the Occupational Therapist (OT) revealed that resident #004 was no longer able to transfer safely and required mechanical lift.

The Physiotherapist's Quarterly reassessment completed on a date around the same time period as the OT assessment, revealed the resident's transfer ability had declined from a two person transfer to a mechanical lift.

The Minimum Data Set (MDS) Quarterly Assessment completed around the same time period in 2017, revealed the resident was transferred mechanically.

However, the written plan of care revealed the resident required extensive assistance with transfers with weight bearing support provided by two staff.

The DOC acknowledged the plan of care had not been updated when the resident's transfer ability had declined from a two person extensive assist to a mechanical lift transfer.

The plan of care for resident #004 was not reviewed and revised at least every six months and at any other time when the resident's care needs changed. (Inspector #130).

B) The plan of care for resident #006 revealed they had impaired skin integrity to more than one area. The nutritional assessments completed by the Registered Dietitian on two separate dates in 2017, identified the resident as high nutritional risk. However, the written plan of care identified the resident as moderate nutritional risk.

The DOC and the FSS acknowledged the written plan of care had not been updated when the resident's nutritional risk status changed from moderate to high risk. (Inspector #130). [s. 6. (10) (b)]

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 the residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ont. Reg. 79/10 s. 48 (1) 1, requires the licensee to ensure that a falls prevention interdisciplinary program is developed and implemented in the home, to reduce the incidence of falls and the risk of injury.

The home's Fall Prevention and Restraint Reduction Policy, document #09-02-04, revised January 2017 was reviewed. It described the role of registered staff, and directed registered staff to initiate a head injury routine (HIR) for all unwitnessed falls, and witnessed falls that may have resulted in a possible head injury or if the resident was on anticoagulant therapy.

A) On an identified date in 2017, resident #001 sustained a fall. A review of the progress notes for this resident revealed the fall was unwitnessed and resulted in an alteration in skin integrity.

A review of the clinical health record was conducted, and a HIR was not initiated. An interview was conducted with staff #140, and it was acknowledged that a HIR was not initiated for resident #001. (Inspector #611).

B) On an identified date in 2017, resident #003 sustained a fall. A review of the progress notes for this resident revealed the fall was witnessed by a fellow resident, and it was documented that resident #003 hit their head during the fall.

A review of the clinical health record was conducted, and a HIR was not initiated. An interview was conducted with staff #140, and it was acknowledged that a HIR was not initiated for resident #003.

C) Resident #004 sustained unwitnessed falls on two identified dates in 2017. Staff #140 acknowledged the falls were unwitnessed on both identified occasions and that staff had not initiated HIR for either fall. (Inspector #130).

In an interview conducted with the DOC, it was acknowledged that the home did not comply with their policy titled: Falls Prevention and Restraint Reduction, #09-02-04, revised January 2017. [s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was: reported to the resident, the resident's Substitute Decision Maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) A review of the Medication Incident Reports reported from over a six month period in 2017 revealed that 21 of 46 recorded incidents had not been reported to the SDM, Attending Physician or the Medical Director.

The DOC acknowledged that only medication incidents that "reached the resident" were reported to the SDM, Attending Physician or the Medical Director and that not all medications incidents were reported to all parties. (Inspector #130). [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed.

A) A review of the Medication Incident Reports reported over a six month period, revealed that on at least 14 of 46 occasions, the analysis of the medication incident nor the corrective action taken was consistently documented on the Medication Incident Report.

This information was acknowledged by the DOC. (Inspector #130). [s. 135. (2)]

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 every medication incident involving a resident and every adverse drug reaction is: reported to the resident, the resident's Substitute Decision Maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider and to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the continence program provided for assessment and reassessment instruments.

A) According to the home's Continence Program, if a change in a resident's continence status was identified during the 14-day observation period at the time of the MDS Quarterly or Full Assessment period, staff were required to conduct an additional three-day follow-up observation, to enure accuracy of the change, but not required to complete a reassessment. The RAI Coordinator acknowledged that the home had not developed or implemented a clinically appropriate assessment instrument specifically designed for the assessment of continence.

The DOC acknowledged the Continence Program did not provide assessment and reassessment instruments. (Inspector #130). [s. 48. (2) (b)]

Issued on this 30th day of June, 2017

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

Original report signed by the inspector.