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
Aug 30, 2019	2019_573581_0012	011993-19	Critical Incident System

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

DIANNE BARSEVICH (581)

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): August 9, 12, 13, and 14, 2019.

The following Critical Incident System inspection was completed:
log #011993-19- related to prevention of neglect

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Administrative Assistant/Receptionist and residents.

During the course of the inspection, the inspector reviewed clinical health records, reviewed investigation notes, observed the provision of care, reviewed relevant policies and procedures.

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

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

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

Review of the investigation notes indicated that on an identified date in June 2019, resident #001 had a specific device in place for an extended period of time.

Review of the Kardex identified that resident #001 was to have a specific intervention at a specified time when in bed.

In an interview with PSW #110, they stated they provided the specific intervention to resident #001, once during the shift; however, confirmed they did not provide the specific intervention at the specified times as directed by the plan of care.

During an interview with the DOC, they stated they confirmed that on an identified date in June 2019, resident #001 was not provided the specific intervention at the specified times by PSW #110 and #111.

The DOC confirmed that care set out in the plan of care was not provided to resident #001 as specified in the plan. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were not neglected by the licensee or staff.

O.Reg. 79/10, s. 5, the definition of neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well being of one or more residents.

A Critical Incident System (CIS) was submitted to the Director on an identified date in June 2019, related to allegations of neglect towards a resident.

A review of the licensee's investigation notes identified that PSW #104 reported to the Director of Care (DOC), they provided resident #001 a specific device on an identified date in June 2019. They acknowledged they did not remove the device prior to their shift ending and did not report to the oncoming shift that the device was in place.

In an interview with PSW #104 and #105, they both acknowledged they provided care to the resident with a specific device on an identified date in June 2019 and confirmed they did not remove the device or inform the oncoming shift that the resident still had the device in place when their shift ended.

Review of the plan of care identified that resident #001 was to have a specific intervention at a specified time with an identified level of assistance.

Review of Point of Care (POC) documentation on an identified date in June 2019, indicated that PSW #111 provided resident #001 the specific intervention at two specified times. PSW #110 documented on an identified date in June 2019, they provided the intervention to the resident at two additional specific times during their shift.

In an interview with PSW #110, they stated they provided the specific intervention to the resident once during the shift on an identified date in June 2019; however, stated they did not observe that the resident had the specific device in place. They stated the resident was to have a specific intervention at specified times and confirmed they did not provide the specific intervention as required in the plan of care. PSW #110 acknowledged they documented in Point of Care that they performed the specific intervention with the resident; however, confirmed they did not complete the task as

documented. They acknowledged that they did not remove the device from the resident and were not aware the device was in place. PSW #110 stated the resident does not usually have a device in place.

During an interview with PSW #103 they stated on an identified date in June 2017, they provided care to resident #001 and found the resident had the device in place. They required assistance of another PSW to remove the device and identified altered skin integrity, provided treatment and continued with care.

Review of the skin and wound assessment completed on an identified date in June 2019, identified the resident had altered skin integrity and treatment was provided.

In an interview with DOC they acknowledged that resident #001 had a device in place for an extended period of time when PSW #104 and #105 did not remove the resident from the device on an identified date in June 2019. PSW #110 and #111 failed to provide the specified intervention to the resident during their shift as required in the plan of care and did not remove the device.

The DOC confirmed that resident #001 was neglected by PSW #104, #105, #110 and #111 when the resident was provided with a specific device for an extended period of time, was not provided a specific intervention at specified times which resulted in altered skin integrity and required treatment. [s. 19. (1)]

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 residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 6th day of September, 2019

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

Original report signed by the inspector.