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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
May 27, 2015	2015_248214_0013	H-002329-15	Complaint

Licensee/Titulaire de permis

NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH
413 Linwell Road St. Catharines ON L2M 7Y2

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

INA GRAFTON-GAGE HOME
413 Linwell Road St Catharines ON L2M 7Y2

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

CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 28 and May 1, 2015.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO); Director of Resident Care (DRC); Manager Environmental Services; Personal Support Workers (PSW); Registered Nurses (RN); Registered Practical Nurses (RPN) and residents. The inspector also reviewed clinical records; relevant policies and procedures; the home's concern log and observed the provision of resident care.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **3 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 the resident was 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 or care set out in the plan was no longer necessary.

A) A review of resident #100's clinical record for an identified period of seven months indicated that the resident had sustained 31 falls and that many of these falls were as a result of the resident using their bed rails to pull themselves around the bed and potentially, out of their bed. A review of the resident's progress notes indicated that on an identified date in 2015, the home removed the resident's bed rails following an ineffective trial of keeping the bed rails down, whereby the resident was able to pull the bed rails back into an upright position. A review of the resident's current written plan of care indicated under the falls focus that staff would reinforce the need for the resident to call for assistance and under the mobility focus, indicated that the resident had bed rails in place that were used for bed mobility. An interview with the DRC and registered staff confirmed that the resident was no longer capable of calling for assistance; did not call for assistance for any of the falls identified above and that half bed rails were no longer in place. The DRC confirmed that the resident's plan of care was not reviewed and revised when their care needs changed and when care set out in the plan was no longer necessary.

B) A review of resident #200's clinical record for an identified period of seven months indicated that the resident had sustained 7 falls over this time period as a result of transferring themselves. A review of the resident's current written plan of care indicated under the falls focus that staff would reinforce the need for the resident to call for assistance. An interview with the DRC and registered staff confirmed that the resident was no longer capable of calling for assistance; did not call for assistance for any of the falls identified above and that the resident's plan of care was not reviewed and revised when their care needs changed.

C) A review of resident #300's clinical record for an identified period of seven months indicated that the resident had sustained 2 falls over this time period as a result of transferring themselves. A review of the fall progress note that was completed for a fall on an identified date in 2015, indicated that the call bell was on but that the resident was not able to understand how to use it. A review of the resident's current written plan of care indicated under the falls focus that staff would reinforce the need for the resident to call for assistance. An interview with the DRC and registered staff confirmed that the

resident was no longer capable of calling for assistance; did not call for assistance for any of the falls identified above and that the resident's plan of care was not reviewed and revised when their care needs changed. [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 that resident's including resident #100, #200 and #300 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 or care set out in the plan is no longer necessary, 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 was complied with.

1. A review of the home's complaint policy titled, Reporting and Managing Complaints (LTC-03-02-01 and dated October 2014) indicated the following:

i) All concerns about resident care and Niagara Ina Grafton Gage Village operations shall be taken seriously and be investigated and addressed in a timely manner.

ii) Under "Required Documentation", using the Resident/Family Concern Log, NIGGV shall keep a documented record of complaints that shall include:

- the nature of each verbal or written complaint;
- the date the complaint was received;
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- the final resolution, if any;
- every date on which any response was provided to complainant and a description of the response, and any response made in turn by the complainant.

An interview with the CEO and DRC indicated that the family of resident #100 had placed a concern to them regarding the care of resident #100 on an identified date in 2015. A review of the home's Resident/Family Concern Log indicated that this concern had not been entered on the log form. The CEO confirmed that the home's concern log was not updated with this concern and that the home did not comply with their policy.

2. A review of the home's policy titled, Falls Prevention and Management (LTC-03-06-06 and dated March 2014) indicated the following:

i) The DRC will complete a Post Fall Screen for Resident/Environmental Factor (Appendix D) as quickly as possible after the fall, assessing environment, review of progress note documentation and interviewing of staff where necessary.

ii) DRC will redo the Morse Fall Scale (Appendix A) if:

- Two (2) falls in seventy two (72) hours.

A review of the resident's progress notes for an identified period of 28 consecutive days in 2015, indicated that resident #100 sustained falls on four different dates during the identified time period and that each fall was within 72 hours of the next fall. A review of the resident's clinical record indicated that no Post Fall Screen for Resident/Environmental Factor (Appendix D) and no Morse Fall Scale (Appendix A) had been completed for these falls. An interview with the DOC confirmed this had not been completed and the home did not comply with their policy.

3. A review of the home's policy titled, Restraint Policy (LTC-03-06-01 and dated with a

revised date of June 2011) indicated the following:

i) Under "Bed rails", bedrails shall be up when the resident is in bed in the following circumstances:

- Resident requests one (1) or both siderails up per choice or to use for bed mobility.
- Where the resident is not capable, POA has requested one (1) or both siderails up after being informed of potential risk for injury.

A review of resident #100's clinical records indicated that on an identified date in 2015, the resident's bed rails were removed from their bed as the home determined them to be a safety risk. The power of attorney (POA) of resident #100 requested that the bed rails be put back on the resident's bed on several occasions, following being informed of the potential risk for injury. An interview with the DOC confirmed that currently, the resident's bed rails remain removed from their bed; the POA has been informed of the potential risk for injury; that the home is planning on making revisions to this policy; however; the policy currently in place and followed, was not complied with. [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 is complied with including the policies identified in this report, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

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

A) A review of resident #100's clinical records for an identified period of seven months indicated that the resident had sustained 31 falls. A review of the resident's current written plan of care indicated under the falls focus that the resident was to be checked every one hour to ensure their safety.

B) A review of resident #200's clinical records for an identified period of seven months indicated that the resident had sustained 7 falls over this time period as a result of transferring themselves. A review of the resident's current written plan of care indicated under the falls focus that the resident was to be checked every one hour to ensure their safety.

C) A review of resident #300's clinical records for an identified period of seven months indicated that the resident had sustained 2 falls over this time period as a result of transferring themselves. A review of the resident's current written plan of care indicated under the falls focus that the resident was to be checked every one hour to ensure their safety.

An interview with front line staff and the DRC confirmed that resident #100, #200 and #300 are checked hourly; however; the home does not have a process to document the safety checks and that these actions taken, had not been documented. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

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Issued on this 17th day of June, 2015

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

Original report signed by the inspector.