Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 16, 2021 | 2021_704682_0019 | 016014-21 | Complaint |

## Licensee/Titulaire de permis

Niagara Health System
63 Third Street Welland Hospital Site Welland ON L3B 4W6

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

Niagara Health System, Welland Hospital Site, Extended Care Unit
65 Third Street Welland ON L3B 4W6

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

AILEEN GRABA (682)

## 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): October 25, 26, 27, 28, 29, November 1, 2, 3, 4, 2021.**

**The following Complaint inspection was completed:**
**016014-21 related to plan of care and falls prevention.**

**The following Critical Incident System inspection(s) were completed concurrently:**
**000115-21 related to the prevention of abuse and neglect**
**005183-21 related to the prevention of abuse and neglect**
**013411-21 related to falls prevention.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Program Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Recreation Therapy Aides (RTA), Housekeeping staff, Personal Support Workers (PSW) and residents.**

**During the course of this inspection, the inspector observed Infection Prevention and Control (IPAC) procedures, the provision of resident care and reviewed clinical health records, investigation notes, staff training records, staffing schedules, meeting minutes, program evaluations and policy and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Nutrition and Hydration**
**Personal Support Services**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Two personal support workers (PSW) were transferring a resident when the mechanical lift started to tip over to one side which lead the PSWs to lower the resident to the floor. An inspection of the mechanical lift after the incident completed by the home confirmed that it was in working order and safe to use.

An registered nurse (RN) stated that they were notified by the PSWs involved and completed a post fall assessment after the incident. The RN could not isolate any contributing factors as a source for the incident. The RN also did not identify any injuries to the resident nor pain as a result. Both PSWs stated that they were not aware as to why the mechanical lift started to tip over. The Director of Care (DOC) confirmed that the mechanical lift was inspected and was currently in use with no mechanical concerns. The resident was at risk for injury and potential harm when staff did not use safe transferring and positioning techniques.

Sources: Resident's electronic medical record (EMR), Complaint, the home's investigation notes, Interview with PSW's, RN, DOC and other staff. [s. 36.]

***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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.***

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**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 has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied.

In accordance with Ontario Regulation 79/10 s. 48 (1) 1 and in reference to O. Reg s.30 (1) 1, which states the licensee shall ensure that in respect of the organized falls prevention and management program there must be a written description of the program that includes relevant policies and provides for methods to reduce risk.

Specifically, staff did not comply with the licensee's policy for Falls Prevention and Management and Safe Lift and Transfers. The licensee's policy stated that resident transfer assessments were re-evaluated quarterly and as needed with change in status.

Two resident's current plan of care identified that they required assistance with transfers. Further review of the clinical record for an identified time period did not include any quarterly lift and transfer assessments.

A RN stated that quarterly lift and transfer assessments were completed by the physiotherapist (PT). The PT stated that they completed quarterly lift and transfer assessments with residents that participated in a therapeutically prescribed activation program. The PT confirmed that they did not complete quarterly transfer assessments for either resident as they were not part of the home's physiotherapy activation program. The RN confirmed that quarterly transfer assessments were not completed for either resident.

Sources: Electronic Medical Record (EMR), Safe Lift and Transfer Policy, Interviews with RN, PT, and other staff. [s. 8. (1)]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

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

**s. 73. (2) The licensee shall ensure that,**
**(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).**
**(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Lunch service was observed in the dining area of the home. Two resident's written plan of care indicated that they required assistance with eating. They were observed with their first course, in front of them on the table and a staff member was not available to provide the assistance they required. A PSW acknowledged that residents should not be served a meal until someone was available to provide assistance to them.

Sources: Complaint, dining observations, interview with PSW and other staff.

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**Issued on this 17th day of November, 2021**

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

**Original report signed by the inspector.**