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 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
Dec 11, 2018	2018_577611_0018	006882-18, 009862-18, 021420-18, 024496-18, 024580-18, 027634-18	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way 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 ou des inspecteurs

KELLY CHUCKRY (611)

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): October 26, 29, 30, 31, November 1, 2, 7, and 8, 2018.

This Critical Incident inspection was conducted concurrently with a complaint inspection. The complaint inspection has been captured in report #2018_577611_0019/006675-18, and includes the following Critical Incident inspections:

Log 006882-18 pertaining to Personal Support Services, Skin and Wound Care, and the Prevention of Abuse and Neglect
Log 027634-18 pertaining to the Prevention of Abuse and Neglect
Log 021420-18 pertaining to the Prevention of Abuse and Neglect
Log 024580-18 pertaining to the Prevention of Abuse and Neglect
Log 009862-18 pertaining to the Prevention of Abuse and Neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Director of Resident Care (ADRC), Programs Manager, Clinical Documentation and Information Coordinator (CDI Coordinator), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and a physician.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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. (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, (c) care set out in the plan has not been effective.

The home submitted a Critical Incident Report, Log #024496-18. Upon review of the report, and the clinical health records for resident #002, it was identified that an incident occurred in August 2018. Resident #002 required assessment at another facility, and returned back to the home less than 24 hour later with a confirmed injury.

In August 2018, the home initiated a significant change assessment in MDS. The written plan of care for resident #002 identified that this resident continued to be at risk for injury. An assessment was completed in August 2018, and identified that resident #002 had another incident, which required a second assessment at another facility. In August 2018, the written plan of care pertaining to preventing incidences for resident #002 was not updated when the plan of care had not been effective.

In an interview conducted with identified staff #101 it was confirmed that interventions were not revised for resident #002. In a subsequent interview conducted in October 2018, with the ADRC and CDI Coordinator, it was confirmed that the plan of care for resident #002 was not reviewed and revised when the plan of care was not effective. [s. 6. (10) (c)]

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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (c) care set out in the plan of care has not been effective, 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 where the Act or 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 with.

In accordance with O. Reg. 79/10, s. 48 (1), the licensee was required to ensure that a falls prevention and management program was developed and implemented in the home to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's policy entitled Falls Prevention Program, MP00-002 last reviewed in October 2018 with no revisions, which is part of the licensee's falls prevention and management program.

Under the Fall Risk Assessment for Residents section of the policy, it identified that "where a resident is identified as having three or more falls or near misses in a 30 day period, a leaf motif will be placed with transfer logos of that resident and attach a leaf motif to resident's personal equipment".

A) Upon review of the clinical health record for resident #002, it was identified that this resident fell an identified number of times, during a specific period of time in August and September 2018.

The plan of care current on an identified date in September 2018, did not identify the intervention in resident #002's plan of care, despite meeting the criteria set in the above noted policy.

An interview was conducted with the ADRC, and the CDI Coordinator in October 2018,

and it was confirmed that the specified policy intervention was not implemented for resident #002 after they fell an identified number of times, during a specific number of days. It was further confirmed that the home did not comply with their Falls Prevention Program policy.

B) Upon review of the clinical health record for resident #005, it was identified that this resident fell a specified number of times over an identified number of days in July and August 2018.

The plan of care current in October 2018, did not identify the intervention in resident #005's plan of care, despite meeting the criteria set in the above noted policy.

Resident #005 was observed oi October 2018, and this resident did not have a specified intervention attached to any piece of personal equipment. The specified intervention was also not present in resident #005's room. An interview conducted with identified staff #116 confirmed that this resident did not have a specified intervention in place for falls prevention.

An interview was conducted with the ADRC, and the CDI Coordinator in November 2018, and it was confirmed that the intervention was not implemented for resident #005 after they fell. It was further confirmed that the home did not comply with their Falls Prevention Program policy. [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 where the Act or the Regulation requires the licensee of a long term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person was taken to hospital. O. Reg. 79/10, s. 107 (3).

The home submitted a Critical Incident Report, Log #024496-18. Upon review of the report, and the clinical health records for resident #002, it was identified that an incident occurred in August 2018. Resident #002 required assessment at another facility, and returned back to the home less than 24 hour later with a confirmed injury.

Upon review of resident #002's MDS assessment, the home initiated a significant change in status observation period for this resident upon their return back to the home. The Critical Incident Report was not submitted within one (1) business day after the incident.

In an interview conducted with the ADRC, and the CDI Coordinator in October 2018, it was confirmed that the home did not notify the Director no later than one business day after this injury for resident #002, which resulted in the transfer to another facility. [s. 107. (3) 4.]

Issued on this 8th day of January, 2019

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

Original report signed by the inspector.