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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 6, 2014	2014_275536_0013	H-000423-14,H-000467-13	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, 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

CATHIE ROBITAILLE (536), SUSAN PORTEOUS (560)

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): May 27, 28 and 29, 2014

During the course of the inspection, the inspector(s) spoke with regulated and unregulated nursing staff, Resident & Community Programs Manager, Dietary Manager, RAI Co-Ordinator, Building Services Manager, Director of Resident Care and the Administrator

During the course of the inspection, the inspector(s) reviewed clinical records, call bell reports and reviewed the home's policies on: Heat Risk, Fall Prevention and Pain Management

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition

Findings of Non-Compliance were found during this inspection.

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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's substitute decision maker had an opportunity to participate in the implementation of the residents' plan of care in relation to the following:

On an identified date in 2014 resident #001's health status began to change and new orders were received by the resident's physician. At that time, the substitute decision maker was notified of the physicians visit. Clinical records identified that the next day resident #001 continued to decline and the substitute decision maker and the physician were not contacted and informed of change in status.The following day the resident #001's condition deteriorated significantly beginning on the day shift. Once again, the physician or the substitute decision maker were not notified. Two hours following the start of the evening shift the substitute decision maker called into the home asking the RN the status of resident #001. The Registered Nurse (RN) advised the substitute decision maker that resident #001 had not yet been seen however, they would be going to see the resident soon. Clinical records by the RN identified that the resident had a further decline in health status from the previous shift. The RN then called the substitute decision maker who was updated, and advised RN to transfer resident to hospital. The substitute decision maker was upset that they had not been contacted earlier. This was confirmed by the Director of Resident Care (DRC). [s. 6. (5)]

2. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs changed in relation to the following:

On an identified date in 2014 resident #001's health status began to change and new orders were received by the resident's physician. The next day, resident #001 continued to decline and the substitute decision maker and the physician were not contacted and informed of this change in status. The following day, resident #001's condition deteriorated significantly beginning on the day shift. This change in status was not communicated to the physician or the substitute decision maker. On the evening shift resident #001's condition further declined. As a result, the plan of care was not reviewed or revised based on this change in care needs. This was confirmed by the Director of Resident Care (DRC). [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 and ensuring that the resident's substitute decision maker have an opportunity to participate in resident's plan of care and that the plan of care is reviewed and revised 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 did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with:

The home's policy #MP00-002 [Falls Prevention Program] last revised on June 20, 2013 directs that an unwitnessed fall be treated as a fall involving a head injury or if the resident is on anticoagulant therapy Glascow Coma Scale (GCS) must be initiated. On May 29, 2014 the Director of Resident Care (DRC) confirmed this information. The clinical records of three residents who had sustained a total of five falls were reviewed which identified that four of these falls were unwitnessed.

A)Resident #006 had three falls on an identified date in 2013. The falls which occurred at 0600 hours(hrs) and at 1700 hrs were unwitnessed. A review of resident #006's clinical record identified that a GCS form was not completed for either unwittnessed fall. This was confirmed by the Director of Resident Care (DRC) during an interview on May 29, 2014.

B)Resident #007 did not have a GCS form initiated for their unwitnessed fall which occurred at 0600 hrs on an identified date in 2014. Registered staff reviewed resident #007's chart and confirmed a GCS had not been initiated.

C)Resident #008 sustained a fall on an identified date in 2013 at 1915 hrs. Resident #008's clinical record identified that a GCS form was initiated.

D)A GCS form was not initiated for three of four (75%)of the unwitnessed falls reviewed. [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 and ensuring that policies are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written hot weather related illness prevention and management plan for the home met the needs of the residents in accordance with evidence-based practices in relation to the following:

In the afternoon of an identified date in 2013, the activation department commenced a reading program which took place outside in a courtyard of the facility. Four residents were in attendance. The residents were placed in the shade under an umbrella and there was a breeze of 19 to 26 km/hr however, the temperature was 29.5 Celcius with a humidex of 41. Clinical records identified that after 20 minutes resident #006 was noted to be unresponsive, limbs flaccid with head leaning to the side. Resident #006 was brought into the facility and cool cloths were applied to the resident. At that time, the resident went back and forth in responsiveness. Resident #006 was sent to hospital and diagnosed with a heat related illness and returned to the home. Clinical records of Heat Risk Assessments completed for each of the four residents in attendance at the outdoor program. Heat Risk Assessments identified that resident #006, #005 and #004 were each at high risk. The Resident & Community Programs Manager confirmed that the program staff should not have had an outside program on that day. Review of the homes policy RC110103 [Hot Weather Guidelines for Residents] dated April 17, 2013 was not based on the Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Homes-July 2012 requiring that all staff attend annual education and training program on prevention and management of heat related illness. [s. 20. (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 and ensuring that the home's hot weather policy meets the needs of the residents in accordance with evidence-based practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen and where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls in relation to the following:

The home's policy #MP00-002 [Falls Prevention Program]last revised on June 20, 2013 directs that a post-fall assessment is to be completed after each fall sustained by a resident. On May 29, 2014, the Director of Resident Care(DRC)and the RAI MDS Co-Ordinator both confirmed that the post-fall assessment should be completed the same day as the fall. The clinical records of three residents involved in a total of five falls at the home were reviewed.

A)On an identified date in 2013 at 0600 hrs resident #006 sustained a fall at the home. Clinical records identified that a post-fall assessment was not completed until nine days later. On an identified date in 2013 at 1420 hrs and 1700 hrs resident #006 sustained two more falls at the home. Clinical records identified that no post-fall assessment was completed for either of these falls. This was was confirmed by the DRC.

B)On an identified date in 2014 at 0045 hrs resident #007 sustained a fall. Clinical records identified that a post-fall assessment was initiated but not completed. A post-fall assessment was completed for only one of the five falls reviewed. On May 29, 2014 the DRC and the RAI MDS Co-Ordinator both confirmed that the post-fall assessment should be completed the same day as the fall. In conclusion, 80% of the residents falls reviewed did not have a post-fall assessment form completed in a timely manner. [s. 49. (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 and ensuring a post-fall assessment is completed, to be implemented voluntarily.

Issued on this 13th day of June, 2014

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