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
Apr 1, 2019	2019_704682_0006	026699-17, 026724-17, 021583-18	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

AILEEN GRABA (682), LISA BOS (683)

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): March 1, 4, 5, 6, 7, 8, 11, 2019.

The following Critical Incident System inspections were conducted:
026699-17 related to medication management
026724-17 related to the prevention of abuse and neglect
021583-18 related to the prevention of abuse and neglect

The following complaint inspections were done concurrently with the Critical Incident System inspection:
019263-17 related to personal support services, housekeeping, nutrition and hydration, prevention of abuse and neglect, transfer and positioning techniques and communication
012429-18 related to safe and secure home.

The following onsite inquiries were done concurrently with the Critical Incident System inspection:
020449-17 related to fall prevention and management
025785-18 related to fall prevention and management
021574-18 related to prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Administrator; Acting Director of Care (DOC); Food Service Nutrition Manager (FSNM); Registered Dietitian (RD); Resident Assessment Instrument (RAI) Coordinator; registered staff; health care aids (HCA) and residents.

During the course of this inspection, the inspector(s) observed the provision of the care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, policy and procedures, fire safety and emergency evacuation plans and critical incident submissions.

Stacey Guthrie Inspector #750 was present during this critical incident inspection.

The following Inspection Protocols were used during this inspection:

Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 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. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. This non compliance was issued within complaint inspection log# 2019_704682_0007 which was done concurrently with the Critical Incident System inspection. [s. 76. (4)]

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 persons who receive training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. In accordance with O. Reg. 79/10, s. 219 (1) the intervals for the purposes of subsection 76 (4) of the Act are annual intervals, to be implemented voluntarily.

WN #2: 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.

On an identified date, a Critical Incident (CI) was submitted to the Director. A review of the progress notes for resident #004 identified that on an identified date, Health Care Aide (HCA) #105 reported that the resident was upset. The progress note identified that the HCA #105 was providing care, resident #004 became upset and emotional. The progress note further identified that registered practical nurse (RPN) #113 spoke with resident #004, and they identified that they were upset and that they told them they didn't want HCA #105 to assist them. RPN #113 spoke with HCA #105 and identified that they were not to provide care to resident #004. A review of the written plan of care for resident #004 identified that on an identified date, RPN #113 updated the resident's care plan. A progress note, identified that HCA #114 informed RPN #115 that the resident told them that they did not want their assistance. In an interview with the Acting Director of Care (DOC), they acknowledged that the resident's written plan of care was updated after the incident, and that when HCA #114 provided care, it was not in conjunction with their care plan. The home did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when they received a complaint concerning the care of a resident, it was immediately forwarded to the Director.

On an identified date, a Critical Incident (CI) was submitted to the Director. A review of the progress notes for resident #004 identified (HCA) #105 reported that the resident was upset with them. The progress note identified that HCA #105 was providing care and resident #004 became upset, and emotional. The progress note further identified that RPN #113 spoke with resident #004, and they identified that they were upset and did not want HCA #105 providing care. RPN #113 spoke with HCA #105 and identified that they were not to provide care to resident #004. A review of the written complaint identified concerns related to resident #004 and the incident on an identified date involving HCA #105. In an interview with the Acting DOC, they acknowledged that the home completed an internal investigation, they were unable to verify the complaint. The Acting DOC identified that as per the progress note on an identified date, they would not have expected a CI to be submitted to the Ministry of Health and Long-Term Care (MOHLTC) as they felt it did not fit the reporting criteria. In an interview with the Acting DOC on an identified date, they acknowledged that the incident should have been reported, after the complaint was received. The home did not ensure that when they received a complaint about the care of resident #004 was immediately forwarded to the Director. [s. 22. (1)]

WN #4: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to 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): 3. A missing or unaccounted for controlled substance.

A CI was submitted to the Director. According to the home's medication incident documentation system and resident #002 clinical records, they were prescribed a medication to be administered on an identified date. Further review of the medication incident indicated that during the shift count on an identified date, the dose of medication was missing.

During an interview, the Acting DOC stated that the missing dose was never found despite an investigation, and that it was not reported within one business day after the occurrence of the incident. The home failed to inform the Director of the missing controlled substance within one business day after the occurrence of the incident. [s. 107. (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was: (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider

A CI was submitted to the Director. According to the home's medication incident documentation system and resident #002 clinical records, they were not administered a medication on an identified date as prescribed. Further clinical record review indicated that the medication incident was not reported to the resident's substitute decision maker (SDM). During an interview, the Acting DOC stated that the missing dose was not found and that resident #002 was not provided a subsequent dose by RPN #116. The Acting DOC also stated that resident's #002 SDM should have been informed that the medication was not given on the identified date.The home failed to ensure that every medication incident involving resident #002 was reported to their SDM. [s. 135. (1)]

Issued on this 4th day of April, 2019

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

Original report signed by the inspector.