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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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
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Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 3, 2018	2018_704682_0013	010794-18	Resident Quality Inspection

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), JESSICA PALADINO (586), KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 28, 29, 30, 31, June 6, 7, 8, 11, 2018.

The following inspections were completed concurrently with the Resident Quality Inspection.

Critical Incident System Reports:
007585-18 related to infection prevention and control
005993-18 related to infection prevention and control
011976-18 related to fall prevention, personal support services, plan of care
002312-18 related to plan of care

The following inquiries were completed concurrently with the Resident Quality Inspection:
006681-18 related to fall prevention, plan of care, reporting of complaints
003967-18 related to infection prevention and control, housekeeping, personal support services
013074-17 related to fall prevention, plan of care
024191-17 related to crisis placement

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Dietitian, Food Services Supervisor (FSS), Resident Council President, residents and their families.

During the course of the inspection, the inspector(s) conducted a tour of the home, including resident rooms and common areas, reviewed infection prevention and control, housekeeping and maintenance procedures, reviewed documentation and relevant clinical records, reviewed relevant policies, procedures, and practices within the home, reviewed meeting minutes, investigation notes and observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 VPC(s)**
- **1 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 O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used equipment, supplies, devices, assistive devices and positioning aids in the home in accordance with manufacturers' instructions.

A clinical record review revealed that on an identified date, staff #110 was assisting resident #012 when the resident had a fall. As a result of the fall, resident #012 sustained injuries requiring medical intervention. Further record review included an assessment on an identified date, that indicated a contributing factor to resident's #012 fall was a fall prevention strategy that was not correctly in place.

During an interview, staff #113 and #115 stated that staff #110 had informed them that the fall prevention strategy was in place when resident #012 fell. During an interview staff #110 stated that the fall prevention strategy was in place as per the home's education prior to the incident, but were now aware that the fall prevention strategy may not have been correctly in place since attending additional training post incident. The DOC was not able to provide manufacturers' instruction for the fall prevention strategy but did provide written instructions related to the implementation of the fall prevention measure. The DOC confirmed that to their knowledge this information met manufacturers' specifications and was communicated to staff as part of the annual training in the home. The home failed to ensure that staff had implemented a fall prevention strategy to resident #012 prior to the incident in accordance with manufacturers' instructions.

PLEASE NOTE: This non compliance was identified during a critical incident system (CIS) inspection, log #011976-18 conducted concurrently during this RQI. [s. 23.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 devices or techniques when they assisted residents.

A clinical record review revealed staff #110 was transferring resident #012 when the resident had a fall. As a result of the fall, resident #012 sustained injuries that required medical intervention. During an interview, staff #113 stated that resident #012 required the physical assistance with two staff to transfer. During an interview, staff #110 confirmed they transferred resident #012 on their own. During an interview, the DOC stated the resident was not transferred as per their plan of care. The home failed to ensure staff used safe transferring techniques when assisting the resident #012. s. [s. 36.] (682)

PLEASE NOTE: This non compliance was identified during a critical incident system (CIS) inspection, log #011976-18 conducted concurrently during this RQI. [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 devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug was prescribed for the resident.

According to the home's medication incident documentation system and resident #010 clinical records, they were prescribed a medication. Staff #108 administered a medication that was not prescribed to them on an identified date in 2017. During an interview, staff #108 stated they were confused and they ended up administering the wrong medication. The physician was contacted and the prescribed medication was held. Staff #108 confirmed that resident #108 had been administered a medication that had not been prescribed to them. [s. 131. (1)]

2. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

According to the home's medication incident documentation system and resident #011 clinical records, they were prescribed a medication. Further clinical record review indicated that on an identified date in 2017 the medication was signed as given by staff #109. Resident's #011 dose of medication on the identified date in 2017 was later found in the medication cart indicating that it was not given. During an interview, staff #109 stated that they signed the dose as given prior to the administration of the medication on the identified date in 2017 to resident #011. Registered staff #109 stated that on the identified date, they became distracted and did not give resident #011 their medication Staff #109 confirmed that they did not administer resident's #011 medication in accordance with the directions for use as specified by the prescriber. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug is prescribed for the resident and; to ensure that drugs are administered to residents in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

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

Issued on this 10th day of July, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AILEEN GRABA (682), JESSICA PALADINO (586), KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2018_704682_0013
Log No. / No de registre :	010794-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 3, 2018
Licensee / Titulaire de permis :	Niagara Health System 63 Third Street, Welland Hospital Site, WELLAND, ON, L3B-4W6
LTC Home / Foyer de SLD :	Niagara Health System, Welland Hospital Site, Extended Care Unit 65 Third Street, WELLAND, ON, L3B-4W6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Smith

To Niagara Health System, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 23.
Specifically, the licensee must:
1. Ensure resident #012 and any other resident have fall prevention strategies in place by staff according to manufacturers' instructions.
2. Provide staff #110 retraining regarding fall prevention strategies for residents and maintain a record for the retraining.
3. An auditing process is implemented to ensure that all staff are safely using and applying the lap belt with the tub chair lift as per the information communicated during training.
4. Ensure the auditing process is documented and retained related to the safe use of the lap belt.

Grounds / Motifs :

1. 1. The licensee failed to ensure that staff used equipment, supplies, devices, assistive devices and positioning aids in the home in accordance with manufacturers' instructions.

A clinical record review revealed that on an identified date, staff #110 was assisting resident #012 when the resident had a fall. As a result of the fall, resident #012 sustained injuries requiring medical intervention. Further record review included an assessment on an identified date, that indicated a contributing factor to resident's #012 fall was a fall prevention strategy that was not correctly in place.

During an interview, staff #113 and #115 stated that staff #110 had informed them that the fall prevention strategy was in place when resident #012 fell.
During an interview staff #110 stated that the fall prevention strategy was in

place as per the home's education prior to the incident, but were now aware that the fall prevention strategy may not have been correctly in place since attending additional training post incident. The DOC was not able to provide manufacturers' instruction for the fall prevention strategy but did provide written instructions related to the implementation of the fall prevention measure. The DOC confirmed that to their knowledge this information met manufacturers' specifications and was communicated to staff as part of the annual training in the home. The home failed to ensure that staff had implemented a fall prevention strategy to resident #012 prior to the incident in accordance with manufacturers' instructions.

PLEASE NOTE: This non compliance was identified during a critical incident system (CIS) inspection, log #011976-18 conducted concurrently during this RQI. [s. 23.]

The severity of this issue was determined to be a level 3 as there was actual harm
to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 compliance history as there was previous non-compliance in a similar area that included:
~ O Reg 79/10 s 30(2) voluntary plan of correction (VPC) issued August 2, 2017 (2017_575214_0009);
~ O Reg 79/10 s. 34 (1) (c) written notification (WN) issued August 2, 2017 (2017_575214_0009);
~ LTCHA, s. 6 (1) (c) written notification (WN) issued August 2, 2017 (2017_575214_0009);
~ LTCHA, s. 6 (4) (a) written notification (WN) issued August 2, 2017 (2017_575214_0009);
~O Reg 79/10 s.30(2) voluntary plan of correction (VPC) issued July 20, 2015 (2015_247508_0010.
(682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3rd day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Aileen Graba

Service Area Office / Bureau régional de services : Hamilton Service Area Office