Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: May 4, 2023

Inspection Number: 2023-1118-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Niagara Health System

Long Term Care Home and City: Niagara Health System, Welland Hospital Site, Extended Care Unit, Welland

Lead Inspector	**Inspector Digital Signature**
Angela Finlay (705243)	Angela Finlay Digitally signed by Angela Finlay Date: 2023.05.08 14:53:59 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following dates:
April 6, 11-12, 17-19, 2023 was conducted on-site and April 13, 2023 was conducted off-site.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00005172/ CI: 2607-000002-22 was related to falls prevention and management.
- Intake #00003314/ CI: 2607-000009-22 was related to falls prevention and management.
- Intake #00013309/ CI: 2607-000013-22 was related to falls prevention and management.
- Intake #00021743/ CI: 2607-000001-23 was related to falls prevention and management.

The following intakes were completed in this Complaint inspection:

- Intake #00011065 was related to staffing.
- Intake #00084271 was related to falls prevention and management, resident care, and reporting and complaints.

The following intakes were completed in this Follow up inspection:

- Intake #00013921 was related to safe transferring.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1118-0001 related to O. Reg. 79/10, s. 36 inspected by Angela Finlay (705243)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that the written plan of care provided clear directions to staff and others who provide direct care to a specific resident.

Rationale and Summary
The resident had interventions in their written care plan regarding an adaptive device that stated the intervention needed to be used when the resident was unattended in their bedroom and when the resident was awake for comfort.

The resident had a fall with the documented contributing factor being that the intervention for the residents adaptive device was not in place.

In separate interviews with two different Personal Support Workers (PSWs), a Registered Practical Nurse (RPN) and the Director of Care (DOC), they stated that the intervention for the resident's adaptive device needed to be in place at all times except for meals. The Administrator did not agree and stated that the care plan did not state the intervention needed to be in place at all times and only needed to be used for comfort.

Not providing clear directions around the requirements of the adaptive device may have confused staff about the expectations and placed the resident at risk of not receiving their assessed care needs which may have resulted in their fall.

Sources: The resident's clinical records; and interviews with staff. [705243]

WRITTEN NOTIFICATION: Integration of assessments, care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee failed to ensure that the staff involved in the different aspects of care for a specific resident collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with and complement each other.

Rationale and Summary
A resident had a fall. A RPN documented a detailed description of the fall and stated that it was witnessed by a PSW. That detailed description was then what was reported by the charge nurse to the resident's family and by the DOC to the Director. A separate clinical record stated that the fall was unwitnessed.

During an interview with the PSW involved they stated that they did not see the actual fall and their assessment of what occurred was very different than the documented version of events. The RPN who documented on the fall stated that they thought the PSW witnessed the fall and their assumed reason for the fall was different then what they had originally documented. The RPN assumed the charge nurse went by what they had documented when speaking to the resident's family. The DOC stated that they had relied on the documentation when reporting to the Director but after speaking with staff realized it was unwitnessed and the cause of the fall was likely different then what had been documented. The report to the Director was not updated to include this information.

The Administrator stated they had spoken to the RPN regarding their documentation and that it was expected that the staff would collaborate on the details of the incident but in this instance it may not have happened.

Failing to collaborate on the assessment of the resident resulted in false documentation, confusion amongst staff and the resident's family, and may have led to missed opportunities for appropriate assessments and interventions.

Sources: The resident's clinical records; CI report #2607-000001-23; and interviews with staff. [705243]

WRITTEN NOTIFICATION: Nursing and personal support services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (2)

The licensee failed to ensure that there was a written staffing plan for nursing and personal support services.

Rationale and Summary
In an interview with the Administrator, they stated that the home did not have a formal written staffing plan that included the required elements as outlined in O. Reg. 246/22, s. 35 (3).

Failing to have a written staffing plan may put residents at risk of not receiving their assessed care and safety needs.

Sources: Interview with Administrator. [705243]

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)

The licensee failed to ensure that a documented record was kept in the home for every verbal or written complaint made to the licensee or staff member concerning the care of a resident or operation of the home that included:

(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

Rationale and Summary

The home had a policy titled "Complaints Process", last revised in February 2023, that detailed the above requirements were to be documented on a form titled, "Client Service Response Form".

The DOC received e-mail complaints concerning the care of a resident and operation of the home by a resident's family member on two dates in 2023. Staff had also documented on a progress note on another date that the family member had brought forward concerns of the care being provided and that they had left multiple messages with the DOC that had not been returned.

In an interview with the DOC and Administrator, they stated that some of the concerns had been followed-up with via phone calls with the family member, however, no Client Service Response Form or documented evidence of these actions were completed or able to be provided.

Sources: The resident's clinical records; E-mail correspondence from complainant and DOC; the home's policy titled, "Complaints Process"; and interviews with the DOC and Administrator. [705243]