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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 25, 2018	2018_539120_0017	031853-16, 001839-17, 008027-18	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
2201 St. David's Road P.O. Box 344 THOROLD ON L2V 3Z3

Long-Term Care Home/Foyer de soins de longue durée

Upper Canada Lodge
272 Wellington Street P.O. Box 1390 NIAGARA-ON-THE-LAKE ON L0S 1J0

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

BERNADETTE SUSNIK (120)

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): April 11, 12, 24, 2018

All three critical incidents reviewed were related to an injury requiring a hospital visit.

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Director of Resident Care, Physiotherapist, Physiotherapy Assistant, registered staff, personal support workers, housekeeper, family member and maintenance staff.

During the course of the inspection, the inspector toured the home, observed residents, observed applicable falls prevention devices and assistive devices in use or in place, reviewed resident clinical records and falls prevention policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

7. Physical functioning, and the type and level of assistance that was required relating to activities of daily living; and
19. Safety risks

A) Resident #100 was admitted to the home in January 2016, and arrived with their own assistive device. According to the the home's Physiotherapist, an RPN made a referral for the resident to receive an assessment for use of the assistive device one week later. On the same day, the home's Physiotherapy Assistant made a progress note that the resident's assistive device was reported to be working for the resident. The resident's written plan of care did not include any information about the assistive device or why it was being used. According to the resident's clinical record, the resident was at risk of falls with poor balance several months after admission.

In January 2017, the licensee submitted a critical incident report identifying that the resident sustained an injury. According to PSW #001, who was interviewed during the inspection regarding the incident, the resident was assisted onto their assistive device by the PSW. The PSW reported that the assistive device was not appropriate for the resident's specific physical needs which resulted in the resident falling when they used it. Assessment were completed by registered staff and the Physiotherapist. Neither assessment included any information about the resident's physical requirements for the device or the safety of the assistive device for the resident. Post incident, the resident was provided with a similar but different assistive device by a family member. The resident's substitute decision maker (SDM), who was in the home during the inspection was interviewed and verified that they had brought both of the assistive devices into the home for the resident and were aware of the resident's injury. The SDM stated that although the design of the assistive device was not ideal for the resident's specific physical needs, it was the best they could find to assist the resident. The SDM showed the inspector an accessory that they also brought into the home to be used in conjunction with the assistive device to further accommodate the resident's specific needs. Based on the clinical record, and interviews with the Clinical Director of Care and Physiotherapist, a re-assessment for safety risks or for appropriateness of the assistive device was was not completed. The Physiotherapist, when interviewed via telephone several days after the inspection, was not aware of the accessory and confirmed that no information was in the resident's plan of care regarding it's use or the use of the assistive device.

During the inspection, the same assistive device and accessory as noted above was observed to be in use by resident #100. After discussions with the Clinical Director of Resident Care on the last date of inspection regarding the safety of the assistive device,

it was reported to have been removed from service and replaced with an alternative and more appropriate device one week later.

B) Five other identified resident rooms were randomly checked for similar assistive devices used by resident #100 during the inspection. An assortment of portable and adaptive assistive devices were observed, but were not similar to that seen in use by resident #100. According to the maintenance person (#004) who was interviewed during the inspection, many of the portable assistive devices were new as of 2018 and had replaced older models. The maintenance person reported that the portable assistive devices were installed once the Physiotherapy Assistant put in a request order. When the new assisitve devices were installed by the maintenance person, they were checked to ensure they were safely applied. An assistive device observed in one identified resident room, was not secured safely. The Administrator was informed on the last date of inspection and by end of day, reported that the assistive device was removed. Residents' #104 and #105, who were identified by the Physiotherapist and RPN #006 as requiring assistive devices but did not have any information in their written plan of care identifying the specific assistive device required and the reason for it's use. RPN #006 reviewed the written plan of care for each resident, and confirmed that no information regarding assistive devices was included. [s. 26. (3) 19.]

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 plan of care is based on, at a minimum, an interdisciplinary assessment of the residents' physical functioning, the type and level of assistance required related to activities of daily living and safety risks, to be implemented voluntarily.

Issued on this 4th day of June, 2018

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

Original report signed by the inspector.