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
Téléphone: (905) 546-8294
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
Dec 28, 2017	2017_700536_0024	018919-16, 027900-16	Complaint

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

THE WOODLANDS OF SUNSET
920 PELHAM STREET WELLAND ON L3C 1Y5

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

CATHIE ROBITAILLE (536), CATHY FEDIASH (214)

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): December 5 and 6, 2017.

This inspection was completed concurrently with the Resident Quality (RQI) Inspection.

018919-16-pertaining to: Fall Prevention, Medication Management, Pain, Reporting & Complaints
027900-16-pertaining to: Personal Support Services, Skin & Wounds, Prevention of Abuse, Neglect and Retaliation

During the course of the inspection, the inspector(s) spoke with family members, personal support workers (PSW's), registered staff, Physiotherapist, Resident Assessment Instrument-Minimum Data Set Co-Ordinator(RAI-MDS), Assistant Director of Resident Care (ADRC), Director of Resident Care (DRC) and the Administrator.

During the course of the inspection, the inspector(s): reviewed relevant documents including, health care records, investigation reports, meeting minutes, complaints log and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Pain
Personal Support Services
Reporting and Complaints
Skin and Wound Care

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

2 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 LTCHA, 2007, s. 6. Plan of care

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A) During an interview with the substitute decision-maker (SDM) of resident #013, they expressed that they had not been made aware of the resident sustaining an injury until approximately one week after the injury occurred.

Review of the resident`s progress notes indicated that on an identified date the resident had a noted injury. On another identified date, the Nurse Practitioner (NP) assessed the area and provided orders to the home. Documentation in the resident`s clinical record indicated that the family was contacted on a specified date, regarding new medication orders and at that time was informed of the injury.

Review of the home`s investigative notes indicated that registered staff attempted to contact the family on a specified date, and that they were unable to reach the family. The investigative notes were reviewed related to the communication with the family.

An interview with the Administrator; Director of Resident Care (DRC) and Resident Assessment Instrument-Minimum Data Set Co-Ordinator (RAI-MDS) on an identified date, confirmed that resident`s SDM had not been notified of the NP`s assessment and their orders, and had not been notified of the results of those orders. They also confirmed that the SDM had not been given an opportunity to participate fully in the development and implementation of the resident's plan of care. (Inspector #214)

B) A review of written complaints by the SDM for resident #013 indicated that the resident was to have a specified intervention in place and that the staff had not always done the specified intervention.

A review of progress notes indicated that on an identified date, registered staff had removed the intervention to do an assessment, and noted an alteration in skin integrity and due to these findings the specified intervention was removed.

A review of a Wound Care Assessment in Point Click Care (PCC) on an specified date, indicated that this was the initial assessment for this alteration in skin integrity. The assessment indicated that the SDM was notified of the wound on an identified date, three days prior to registered staff assessing and noting the alteration in skin integrity. An interview with the RAI MDS Co-Ordinator indicated that the wound assessment template may have been copied in which the date of notification would have populated into the copied version.

A review of the home`s investigative notes indicated that staff had removed the specified intervention, and that this had not been communicated to the family.

An interview with the Administrator; DRC and RAI MDS Co-Ordinator confirmed that that the SDM had not been given an opportunity to participate fully in the development and implementation of the resident's plan of care.

(PLEASE NOTE: This evidence of non-compliance related to the above noted non-compliance was found during RQI Inspection #2017_700536_0023/026590-17.) [s. 6. (5)]

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 residents, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was 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): (3.1) (b) Where an incident occured that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident's health condition, the licensee shall (b) where the licensee determines that the injury had resulted in a significant change in the resident's health condition or remained unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

A review of a Critical Incident System (CIS) report dated as occurring on an identified date, indicated that staff noted that resident # 013 had an identified injury and a note was placed in the physician`s book for further assessment. The date and time the CIS was first submitted to the Ministry of Heath was an identified number of days later.

Review of the resident`s clinical records indicated that a Minimum Data Set (MDS) significant change in status assessment was completed on a specified date.

An interview with the Administrator and DON confirmed that it had been greater than three days before the Director had been informed of this incident, when the licensee determined that the injury had resulted in a significant change in the resident`s health condition.

(PLEASE NOTE: This evidence of non-compliance related to the above noted non-compliance was found during RQI Inspection #2017_700536_0023/026590-17.) [s. 107. (3.1)]

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 January, 2018

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

Original report signed by the inspector.