Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Mar 5, 2021	2021_575214_0004	002876-20, 008947-20, 016904-20, 017779-20, 025641-20	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way Thorold ON L2V 4T7

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

CATHY FEDIASH (214)

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): February 3, 4, 5, 8, 10, 11, 12, 17, 18, and 22, 2021, on-site and February 9, and 16, 2021, off-site.

Please note the following:

This inspection was conducted simultaneously with Complaint Inspection #2021_575214_0003.

At the onset of this Critical Incident System (CIS) Inspection the home was not experiencing a disease outbreak. As a result, the Infection Prevention and Control (IPAC) Observational Checklist (A2) - for long-term care homes not in a respiratory infection outbreak, was conducted.

The following intakes were completed during this CIS inspection:

-Log #025641-20- in relation to Hospitalization and Change in Condition.

-Log #017779-20- in relation to Falls Prevention.

-Log #016904-20- in relation to Prevention of Abuse and Neglect.

-Log #008947-20- in relation to Falls Prevention.

-Log #002876-20- in relation to Falls Prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Registered Nursing Staff, Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector reviewed clinical health records and observed the provision of care.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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

- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's written plan of care set out clear directions to staff and others in relation to fall prevention interventions.

A CIS report indicated a resident was injured due to a fall.

The resident was identified as a risk for falling. The resident's plan of care indicated staff were to keep the resident's mobility device away from an identified area when they were asleep to prevent independent transfers. Their plan of care also indicated staff were to keep the resident's mobility device in an identified position and location, to promote the safest means of independent transfer.

The PSW indicated they placed the resident's mobility device in the identified position and location as the resident would not always remember to call and may make attempts to self-transfer. The PSW confirmed the two interventions in the resident's plan of care had not provided clear direction to staff.

When the plan of care contains directions that are not clear to staff who provide care,

there is a risk that staff may not implement the most current direction, placing the resident at risk for falling.

Sources: critical incident system (CIS) report, resident's care plan, and interview with the PSW. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in resident's plan of care related to a safety intervention, was provided.

A CIS report indicated a resident was found with an identified injury. The resident indicated to staff what had occurred but were unable to identify by whom.

The resident’s care plan indicated a safety intervention was to be put in place when the resident was in their room.

Observation of the resident’s bedroom on an identified date, indicated the resident was not in their room at the time of this observation. The safety device was not observed.

A PSW staff indicated they were not aware of the safety intervention. They indicated this intervention was in the resident’s plan of care; however, was not listed as a task in the documentation system.

A RPN staff and another PSW staff confirmed the safety device was required and should be in place when the resident was in their room.

Observation of the resident’s room later this day, indicated the resident was in their room and the safety device was not observed to be in place.

Three days later, observation of the resident’s room indicated the resident was not in their room and the safety device was not observed. The RPN staff indicated they included this intervention to the resident’s task list in the documentation system and it should be in place.

Sources: critical incident system (CIS) report, resident's plan of care, and interview with the RPN and other staff.[s. 6. (7)]

3. The licensee failed to ensure that resident's plan of care was reviewed and revised when a safety intervention, was no longer necessary.

A CIS report indicated a resident was found with an identified injury. The resident indicated to staff what had occurred but was unable to identify by whom.

The CIS and the resident's care plan indicated immediate actions to prevent re-occurrence included the use of a safety device to monitor the resident while they were sleeping.

During an observation of the resident's room, the safety device was not observed.

A PSW staff and a RPN staff indicated the safety device was removed some time ago when the home did a review of the devices in use and determined the resident no longer required one.

The RPN staff indicated the resident's plan of care was not revised when the safety device was determined to no longer be necessary.

Sources: critical incident system (CIS) report, observation of the resident's bedroom and review of their plan of care, and interview with RPN and other staff. [s. 6. (10) (b)]

Issued on this 17th day of March, 2021

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

Original report signed by the inspector.