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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: April 17, 2024	
Original Report Issue Date: April 15, 2024	
Inspection Number: 2024-1612-0001 (A1)	
Inspection Type: Critical Incident	
Licensee: The Regional Municipality of Niagara	
Long Term Care Home and City: The Woodlands of Sunset, Welland	
Amended By Nishy Francis (740873)	**Inspector who Amended Digital Signature** Nishy Francis Digitally signed by Nishy Francis Date: 2024.04.17 11:33:45 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
NC #003 Sources corrected to reflect correct policy revision date,
NC #004 Newly issued Written Notification,
CO #001 has been rescinded.

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Lead Inspector Nishy Francis (740873)	**Additional Inspector(s)**
Amended By Nishy Francis (740873)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 2 - 4, 9, and 10, 2024.

The following intakes were inspected:

- Intake: #00097376 (critical incident) related to falls prevention and management.
- Intake: #00104254 (critical incident) related to infection prevention and control.
- Intake: #00109921 (critical incident) related to infection prevention and control.

The following intakes were completed:

- Intake: #00101754 (critical incident) related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

AMENDED INSPECTION RESULTS

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was

provided to the resident as specified in their plan.

Rationale and Summary
On an identified date, inspector observed a resident in their bedroom seated on a chair, inspector noted the chair did not have the specified falls prevention intervention as per the resident's care plan. Staff observed and confirmed the chair did not have the falls prevention intervention. The residents care plan indicated the chair was to have the falls prevention intervention for the resident.

On the same day, the chair was removed from the resident's room. Progress notes and interviews with the Administrator indicated that the resident did not have concerns with removing the chair.

Sources: Observation of resident's room; interviews with staff; record review of resident's clinical record. [740873]

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
On an identified date, inspector observed a resident's walker. Inspector noted the walker did not have a falls prevention intervention as specified in the resident's plan of care. A staff acknowledged the falls prevention intervention was not present on the resident's walker.

On the same day, staff applied the falls prevention intervention onto the walker.

Sources: Observation of a resident; interviews with staff; record review of resident's clinical record. [740873]

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
On an identified date, inspector observed a resident in their room. Inspector noted a falls prevention intervention was not present as per the resident's care plan. A staff member acknowledged the falls prevention intervention was not present. The staff applied the falls prevention intervention.

Follow up observations indicated the falls prevention intervention was present.

Sources: Observation of resident; interviews with staff; record review of resident's clinical record. [740883]

Date Remedy Implemented: April 2, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home, furnishings and equipment were maintained in safe condition and in a good state of repair.

Rationale and Summary
On an identified date, inspector observed a resident's falls prevention device was

not functioning. A RPN (registered practical nurse) pressed down on the device and no sound was noted. A RN (registered nurse) was also present and stated that the alarm should sound when activated, as it was used as a fall prevention intervention for the resident. The RPN assessed the device and determined the batteries were not inserted as per the manufacturer's directions. The RPN adjusted the batteries and pressed down on the device, this activated the alarm. The RPN could not determine the period of time when the device was not functioning. The Director of Care (DOC) stated the home completed monthly audits of the devices. Review of the most recent audit indicated the device was functioning.

Failure to ensure that devices used for falls prevention were in good repair, put the resident at risk for injury.

Sources: Observation of resident; interviews with RPN, RN and the DOC; review of the monthly chair alarm audit. [740883]

(A1)
The following non-compliance(s) has been amended: NC #003

WRITTEN NOTIFICATION: General Requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident

under the falls program, including assessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
A resident experienced a fall on an identified date. Review of the resident's clinical record indicated the resident's method of transfer after the fall was not documented. A staff and the DOC acknowledged the resident's clinical record did not indicate the method of transfer. The DOC indicated that the method of transfer post fall should have been documented. The home's policy stated staff were to document in the post-fall assessment how the resident was transferred.

When the method of transfer post fall was not recorded, there was risk that the resident's immediate actions post fall were not considered during treatment planning.

Sources: Interviews with staff and the DOC; record review of a resident's progress notes, post fall assessment and the home's policy Post Fall Assessment, Index No: PCS04-011, last revised June 19, 2023. [740873]

(A2)
The following non-compliance(s) has been newly issued: NC #004

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg.

246/22, s. 102 (9).

The licensee has failed to ensure that when a resident experienced symptoms of infection, immediate action was taken to reduce transmission and isolate residents.

Rationale and Summary
On an identified date, a resident experienced symptoms of infection. The resident was not isolated or tested as per the home's policy.

Staff stated that when a resident experienced symptoms of infection, they were to be immediately isolated and tested. The home's policy Outbreak Management – COVID-19 (Confirmed or Suspected), last revised March 4, 2024, indicated that when a resident has new or worsening symptoms that are different from the resident's baseline health status, registered staff are to isolate the symptomatic resident immediately and test for viruses.

When the home failed to take immediate action to reduce transmission and isolate residents, there was a high risk of infection transmission in the home.

Sources: Record review of resident's clinical record, home's policy IC03-007, Subject: Outbreak Management – COVID-19 (Confirmed or Suspected), last revised March 4, 2024; interview with staff. [740873]

(A3)
The following order(s) has been rescinded: CO #001

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).