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
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: November 27, 2024

Inspection Number: 2024-1612-0004

Inspection Type:
Complaint
Critical Incident

Licensee: The Regional Municipality of Niagara

Long Term Care Home and City: The Woodlands of Sunset, Welland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 7-10, 15-18, 2024

The following intake(s) were inspected:

- Intake: #00113174 - Critical Incident M617-000005-24 - related to fall prevention and management.
- Intake: #00124309 - Critical Incident M617-000014-24 - related to respiratory outbreak.
- Intake: #00125234 - Complainant with concerns regarding resident care, restorative care, and personal assistance services device (PASD).

The following intakes were completed in this inspection:

- Intake: #00121575 - Critical Incident M617-000013-24 - related to fall prevention and management.
- Intake: #00127050 - Critical Incident M617-000015-24 - related to fall prevention and management.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when their care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary:
A resident had a significant decline in condition resulting in a change to their care needs.

a) The plan of care for the resident did not reflect their current needs related to

toileting. During interview, the resident and Personal Support Workers stated the resident's needs had changed related to toileting.

A Personal Support Worker stated the resident's plan of care did not reflect how staff were currently caring for the resident and a Registered Practical Nurse (RPN) confirmed that the plan of care was not revised.

The plan of care was not revised when the resident's care needs changed in relation to toileting.

Sources: the clinical health record for the resident, including care records, plan of care, progress notes; and interview with the resident, PSWs, and RPN.

b) The plan of care for the resident was not revised when the care was no longer necessary related to a turning and repositioning schedule.

Rationale and Summary:
The resident's plan of care included a specific turning and repositioning schedule. Turning and repositioning records in Point of Care (POC) reflected that the resident was not routinely being turned and repositioned according to the schedule over the past 30 days.

A Registered Practical Nurse (RPN) stated that the schedule had previously been implemented, however, the specific schedule was no longer required as long as the resident was repositioned every two hours.

The Director of Resident Care stated that the specific turning and repositioning schedule was not required as long as the resident was being turned and repositioned every two hours and the schedule should have been reassessed if it was not consistent with what staff were doing.

Sources: the clinical health record for the resident, including care records, plan of care, progress notes; and interview with the resident, RPN, and DRC.

When the resident's plan of care was not revised when their care needs changed or when the care was no longer necessary, there was a risk that care would not be provided according to the resident's needs and preferences.

WRITTEN NOTIFICATION: Bed rails

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

The licensee has failed to ensure that where bed rails were used, a resident was assessed and the resident's bed system was evaluated in accordance with evidence-based practices to minimize risk to the resident.

Rationale and Summary:
When a resident moved into the home the resident's bed was replaced with a bed that had bed rails attached to the frame. An assessment of the resident related to the bed rails was not completed at the time of the bed transfer. The Registered Nurse confirmed that a bed rail risk assessment or Personal Assistance Services Device (PASD) assessment was not completed for the resident at any time when the bed rails were in place over a six month period. Documentation reflected that

consent for the bed rails was obtained three months after the rails were in place and the rails were not added to the resident's care plan for three months.

The Manager of Long-Term Care Facilities stated that an assessment of the bed system for entrapment risk was completed when the bed rails were originally added to the bed, however, there was no documentation to support that an assessment of the bed system had been completed.

The resident's bed was replaced again after a fall and the rails were added to the new bed. An assessment of the resident in relation to safety for the use of the bed rails was not completed after the fall and there was no documentation to support that the new bed system was assessed for entrapment hazards when the rails were added to it.

The home's restraint and personal assistance services device (PASD) policy directed staff to complete a PASD assessment prior to the application of the bed rails and that consent would be obtained in writing on the General Consent Form before the initial application of the bed rails.

When the resident and their bed system were not assessed for safety and entrapment risks when bedrails were installed, there was a risk of entrapment or injury to the resident.

Sources: clinical health record for a resident, including progress notes, care plan, and assessments; interview with RN, Manager of Long-Term Care Facilities; Maintenance referrals, assessments, and repair records related to the identified beds; policy CS01-002, Restraint and PASD Program.

WRITTEN NOTIFICATION: Falls Prevention Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that strategies to mitigate a resident's risk for falls were implemented.

According to O.Reg. 246/22, s.11 (1)(b), where the Act or Regulation requires the licensee of a long-term care home to have programs or procedures in place, the licensee is required to ensure that the programs and procedures are complied with.

Rationale and Summary:
According to the home's Falls Prevention Program, strategies to mitigate falls included that the registered staff were responsible for identifying residents at risk for falls and communicating this to the interdisciplinary staff face-to-face at each mandatory shift report and, collaborating with the team on any changes that are required to meet resident needs.

A resident had a fall where they sustained an injury and their clinical records showed that they used a wheelchair for ambulation. Several hours prior to the resident's fall, a Physiotherapy (PT) referral was sent indicating that the resident's wheelchair was not functioning properly. The Director of Resident Care (DRC) acknowledged that the expectation was that if the wheelchair was not functioning

properly, the wheelchair should have been removed from the floor and the concern communicated to the Registered Practice Nurse (RPN). There were no progress notes or other records found to support that the concern was communicated to the interdisciplinary team, that the wheelchair was removed, and an alternative assistive device provided.

By not following procedures outlined in the home's falls prevention program to address the resident's wheelchair concerns, this may have contributed to the resident's fall incident.

Sources: Interview with the PT, DRC, and other staff; review of the resident's clinical records, and the home's Falls Prevention Program.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs were stored in a medication cart that was secure and locked.

Rationale and Summary:
A medication cart was left unlocked and unattended by a Registered Practical Nurse (RPN) who was providing medications to residents in the dining room. The RPN was not in the visual sightline of the medication cart and the inspector was able

to open the drawers of the cart and access medications within the cart.

The RPN stated they did not usually lock the medication cart if they were in the dining room providing medications, however, the RPN acknowledged that they did not see the Inspector access the medication cart while it was unlocked.

The Director of Resident Care confirmed that the medication cart should have been locked if it was unattended in the dining room.

When medication carts are left unlocked while unattended, there is a risk that residents will access medications that are not prescribed for them.

Sources: observations; interview with an RPN and DRC.

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

The licensee has failed to ensure that no resident administered a drug to themself unless the administration had been approved by the prescriber in consultation with the resident.

Rationale and Summary:
A physician's order was in place for medications to be administered to a resident. An

order for the resident to self-administer medications was not in place and the Director of Resident Care confirmed the resident did not have authorization to self-administer medications at that time.

The home's medication management policy directed registered nursing staff not to leave medication unattended for residents to self-administer unless the resident performed self-medication administration in adherence to the self-administration of medication policy. The policy also directed staff to observe the ingestion of the medication, or it could not be considered administered.

Progress notes identified that the resident's medication was found on the bedside table and had not been consumed. The Registered Practical Nurse (RPN) confirmed they had left the resident's medication on the resident's bedside table and they did not observe if the resident consumed the medications. The RPN stated they usually went back to confirm if the resident took their medications, however, they did not return to check that shift. The electronic medication administration record (eMAR) was signed, reflecting that the medication was administered, however, the RPN confirmed the medication had not been consumed by the resident.

Sources: clinical health record for a resident, including progress notes and physician orders; interview with RPN and DRC; policy PTH01-028 Medication Management System.

WRITTEN NOTIFICATION: Retention of resident records

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 276 (2)
Retention of resident records
s. 276 (2) A record kept under subsection (1) must be kept at the home for at least

the first year after the resident is discharged from the home.

The licensee failed to ensure that a resident's records were kept at the home for at least the first year after the resident was discharged.

Rationale and Summary:
A resident was discharged from the home less than one year prior to this inspection. The inspector requested to review the resident's clinical records and was informed by the ADOC and Administrator that the records were off-site and would have to be couriered back to the home. The Administrative Assistant (AA) confirmed that there were no resident discharge records kept in the long-term care home.

The Administrator and AA provided the inspectors a single-page copy of the Region of Niagara's By-law Records Retention Schedule. Further review of the By-Law showed that as per the Citation appendix, it included the requirement described above.

The AA acknowledged that there may have been a misinterpretation of the By-law and the requirements for records retention.

Sources: Observations, review of By-Law No. 2023-57, and interview with the AA and Administrator.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:

-Provide re-education to all Personal Support Workers (PSW) and Dietary staff on the home's requirements related to the proper use of personal protective equipment (PPE), specifically during an outbreak.
-Document and maintain a record of the education provided, including the name, role, and signature of the staff who received the education, and the staff member who provided the education. This record must be readily available for inspector review.
-Conduct PPE audits twice a day for two weeks on all units, or until compliance is achieved. Maintain record of the audits, including the date and name of the person who conducted the audit. This record must be readily available for inspector review.

Grounds

The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented. Staff failed to ensure that personal protective equipment (PPE) in place for additional precautions in an outbreak unit was used properly. In accordance with section 9.1, d, of the "Infection Prevention and Control Standard for Long Term Care Homes, revised September 2023" (IPAC Standard), the licensee shall ensure that routine and additional precautions are followed in the IPAC program, and at a minimum shall include the proper use of PPE.

Rationale and Summary:

During observations conducted during an outbreak, staff was observed to have been wearing their masks below their nose. One of the observed staff was observed to pull their mask below their chin to talk to a resident in the dining room. A separate Inspector also observed multiple other staff inappropriately wearing their masks on the outbreak unit.

The staff acknowledged that they had been provided education on the proper use of PPE, and that the expectations were that masks were to be worn appropriately while working on the

outbreak unit by having the mask cover both their mouth and nose. During the observation of the staff, they placed their mask on appropriately when they noticed the Inspector's presence.

The IPAC Lead acknowledged that the expectation was that staff wear their mask appropriately when working on an outbreak unit.

By not wearing PPE properly on an outbreak unit, residents were placed at increased risk of the transmission of infection.

Sources: observations, interview with staff and the IPAC Lead, and review of the home's policy titled, "Surveillance and Reporting Suspected Infection".

This order must be complied with by January 10, 2025.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.