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
Dec 30, 2019	2019_730593_0038	019131-19, 019255-19, 021015-19, 022060-19	Critical Incident System

Licensee/Titulaire de permis

Rural Healthcare Innovations Inc.
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

Dundas Manor Nursing Home
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

GILLIAN CHAMBERLIN (593)

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): December 16 - 20, 2019.

Log #019131-19 (2674-000019-19) and #019255-19 (2674-000020-19) were inspected related to incidents that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the residents health status.
Log #021015-19 (2674-000022-19) was inspected related to resident to resident physical abuse.
Log #022060-19 (2674-000024-19) was inspected related to staff to resident emotional abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Physiotherapist, Registered Nursing staff, Personal support workers (PSWs), Dietary staff and residents.

The Inspector observed the provision of care and services to residents, staff to resident interactions, residents' environment and reviewed resident health care records, investigation records and licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #002's pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate instrument specifically designed for this purpose.

A Critical Incident report (CIS) was submitted to the Director, related to a critical incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. It was reported in the CIS that resident #002 sustained three falls within a 24 hour period, with the third fall resulting in a significant injury.

A review of the progress notes found the following:

Month A: Day 2, 2019- resident returned to the home after 1200 hours. Resident denies pain when asked but when moved, makes a noise. Staff at the hospital were administering Tylenol for comfort.

Day 3, 2019- 0331 hours, PRN (as needed) Tylenol administered for overall body pain and pain related to injury. Resident yelling out with pain during care.

Day 3, 2019- 0959 hours, Tylenol ordered every six hours for five days for pain related to injury.

Day 6, 2019- 0133 hours, resident having pain. Tylenol given as ordered, 0000 hours Tylenol held as resident was sleeping and limit of 3.6g Tylenol ordered per day.

Day 10, 2019- 1307 hours, resident had their bath this morning. Little agitated with their bath, slight pain with their bath.

Day 12, 2019- 1111 hours, front line staff noted resident to have increased pain during cares.

Day 19, 2019- 2246 hours, resident is very vocal during care this evening. Sounded to be in pain. PSWs stated that resident is always like that now. Resident is no longer on any straight pain medication. Residents physician will be in tomorrow- note left for them to assess (note: no progress notes indicating that the physician assessed the resident for pain the following day).

Month B: Day 3, 2019- 1348 hours, residents' family visiting and inquired that if Tylenol

was not effective, they would like the resident to receive something stronger. Writer and family member thought that resident was receiving Tylenol before care. Writer reviewed medications and resident is no longer receiving Tylenol on a regular basis. PSW staff reported that pain has improved but pain still remains with care. Reminder for Tylenol PRN to be given with care in MAR. Pain assessment to be completed one hour after administration of Tylenol during morning care tomorrow morning.

Day 4, 2019, 0749 hours- PRN Tylenol administered, administration was ineffective, PSW reported resident continued to have pain during care.

It was documented in the home's electronic health records that a Pain Assessment was completed November 3, 2019 for resident #002.

A review of the residents eMAR (electronic medication administration record), found the following orders:

October 2019
Acetaminophen tablet 325mg. Give two tablets by mouth every 6 hours for administration for 5 days (650mg). Order date: Month A: Day 3, 2019.
Acetaminophen tablet. Give 650mg by mouth every 4 hours as needed for pain or fever for 2 days. Order date: 2017.

November 2019
Acetaminophen tablet 325mg. Give two tablets by mouth every 6 hours for administration (650mg). Order date: Month B: Day 4, 2019.
Acetaminophen tablet. Give 650mg by mouth every 4 hours as needed for pain or fever for 2 days. Order date: 2017.

During an interview with Inspector #593, December 17, 2019, PSW #100 indicated that resident #002 was experiencing pain when they returned from hospital and that the resident would not initially let staff move their injured area during care. The PSW added that when they started their day shift, if the resident was in pain and care could not be provided, they would ask the night nurse if their pain medication had been administered during the night shift. The PSW indicated that the response was sometimes they had and sometimes they had forgotten, and once the pain medication was administered, the PSW said that they had to wait an hour before being able to provide care.

During an interview with Inspector #593, December 20, 2019, RPN #104 indicated that a

pain assessment for resident #002 should have been completed upon return from hospital however staff knew the resident was in pain and if their was increased pain, they can refer this to the physician for review of their pain medications.

During an interview with Inspector #593, December 20, 2019, the DOC indicated that the expectation was that a pain assessment should be completed for any resident returning to the home with a significant injury and that a pain assessment for resident #002 should have been completed upon return from hospital.

As a result of a fall, resident #002 sustained a significant injury. Upon return from hospital, a regular order of Tylenol was ordered for five days. After the five days, the resident continued to complain of pain related to the fractured shoulder with the administration of Tylenol PRN, however another order of regular Tylenol was not ordered until a pain assessment was completed more than a month after the significant injury occurred. As such, the licensee has failed to ensure that the resident was assessed for pain using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

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 ensuring that when a residents pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #2: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the written plan of care, was

provided to resident #003 as per the plan.

A Critical Incident report (CIS) was submitted to the Director, related to a critical incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. It was reported in the CIS that resident #003 sustained a witnessed fall, which resulted in a significant injury.

A review of resident #003's current plan of care, found several documented fall prevention interventions, including the following:

• Bed is to be in lowest position when in use.

The following was observed by Inspector #593 during the inspection:

December 17, 2019, 1405 hours: resident #003 was observed in bed asleep. The bed was not observed to be in the lowest position. At the time of the observation, Inspector #593 interviewed the residents primary PSW (PSW #103) who confirmed that the bed was not in the lowest position and said that the red tab on the wall by the residents bed, indicated that the bed was to be lowered to the lowest position.

December 18, 2019, 0715 hours: resident #003 was observed in bed asleep. The bed was not observed to be in the lowest position. At the time of the observation, Inspector #593 interviewed the residents primary PSW (PSW #102) who said that they had to check as the home had different beds and some beds they could not lower all the way, as the wheels would unlock. The PSW was able to lower the bed further at this time, with the wheels remaining locked.

December 19, 2019, 0730 hours: resident #003 was observed in bed asleep. The bed was not observed to be in the lowest position. At the time of the observation, Inspector #593 interviewed PSW #100, who was familiar with resident #003 and said that the bed was at the correct height. They further showed the inspector what they explained yesterday, during an interview. There were two tabs on the wall by the bed, the black tab which was the height of the bed during transfers and a red tab which was the height of the bed when the resident was sleeping. Inspector #593 noted that the red tab was approximately 2-3 centimeters lower than the black tab.

During an interview with Inspector #593, December 18, 2019, PSW #100 indicated that when resident #003 was in bed, the bed is kept in the lowest position. They further

explained, that they follow the tabs on the wall, there are two tabs, one for the height of the bed during transfers and one for the height of the bed when the resident was in bed.

During an interview with Inspector #593, December 19, 2019, the Physiotherapist (PT) #101 explained that the red tab posted on the wall, was for the height of the bed when in use and indicated that the bed should be in the lowest position for that bed. The red tabs are part of the falls program and not all residents have a red tab. All residents have a black tab and this is positioned on the wall where the height of the bed should be during transfers. They added that the red tab can be placed anywhere, it is a visual indicator that the bed needs to be lowered all the way, the black tab is at a specific height which is assessed by the PT.

On three occasions, Inspector #593 observed resident #003 in bed when the bed was not in the lowest position. As such, the licensee has failed to ensure that the care set out in the written plan of care, was provided to resident #003 as per the plan. [s. 6. (7)]

Issued on this 30th day of December, 2019

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

Original report signed by the inspector.