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 prévue 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

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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
Jun 18, 2019	2019_593573_0015	008784-18, 010786-18, 014910-18	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Lakefield
19 Fraser Street LAKEFIELD ON K0L 2H0

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

ANANDRAJ NATARAJAN (573)

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): June 10 to 14, 2019.

The following Critical Incident Logs was inspected during this inspection: Log (s) 008784-18, 010786-18 and 014910-18, related to incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Coordinator, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Behaviour Supports Team and Residents.

During the course of the inspection, the inspector observed the provision of care and services to residents, staff to resident interactions and resident to resident interactions. In addition, reviewed licensee investigations notes and licensee's specific policy related to the Pain Management.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O.reg.79/10, 52. (1) and reference with s.52 (2), the licensee was required to ensure that when a resident's pain is not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Specifically, staff did not comply with the licensee's Pain Identification and Management, RC-19-01-01, of the policy which is part of the licensee's Pain program.

On June 11, 2019, at the request of Inspector #573, the Director of Care (DOC) provided policy RC-19-01-01, titled Pain Identification and Management (dated February 2017). The policy directs the Registered Nursing Staff to initiate the Pain Flow record for 72 hours if the resident meets the following criteria (c) There is a dosage increase or decrease of a regular pain medication and (d) PRN pain medication is used for 3 consecutive days. Further, the policy indicated that after 72 hours, if further information is required to manage the resident's pain a Pain Assessment will be completed.

Inspector reviewed resident #001's health care records, which indicated that on a specified date, resident reported concerns with increased pain. In addition to regular pain medication, the resident was administered PRN pain medication. PRN pain medication was administered consecutively for five identified dates. Review of resident #001's health care record indicated that there was no Pain Flow record nor Pain Assessment tool used

for resident #001's pain management.

Inspector reviewed resident #002's health care record. The resident had a fall on a specified date and began to complain of pain. In addition to regular pain medication, the resident was also administered PRN pain medication. PRN pain medication was administered consecutively for six and eight identified dates in a specified month, after the fall incident. Furthermore, on a specified date, there was a dosage increase of a regular pain medication. Review of resident #002's health care record indicated that there was no Pain Flow record nor Pain Assessment tool used for resident #002's pain management.

In an interview Registered Nurse (RN) shared that they had documented resident #001 and #002's pain in the progress notes during the above identified period, but that an electronic Pain Assessment had not been completed.

Inspector #573 reviewed resident #001 and resident #002's health care records in the presence of the DOC. Upon review, the DOC confirmed that electronic Pain Flow record and the Pain Assessment tool were not conducted for resident #001 and #002's pain management as per the licensee's Pain Identification and Management policy. (Log #008784-18 and # 010786-18) [s. 8. (1) (a),s. 8. (1) (b)]

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 to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting resident #001.

A review of Critical Incident Report (CIR) indicated that on a specified date, a PSW staff transported resident #001 from the dining room in a wheelchair without foot rest in place. During the transportation resident #001 was injured. The resident was sent to the hospital and was diagnosed with a specific injury.

Inspector #573 spoke with the DOC, they indicated that the incident was immediately investigated. During the investigation, PSW #101 indicated that while assisting resident #001 in wheel chair, they were not aware if the wheel chair foot rest in place nor if the resident's legs were supported.

The DOC stated to the inspector that on a specified date, PSW #101 failed to follow the safe transferring and positioning techniques when assisting resident #001's transfer from the dining room to the resident's room.(Log #008784-18) [s. 36.]

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 to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 20th day of June, 2019

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

Original report signed by the inspector.