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
Sep 25, 2020	2020_643111_0013	002175-20, 013859-20, 018010-20	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

LYNDA BROWN (111)

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): September 1-4 and 8, 2020.

The following critical incidents were inspected concurrently during this inspection:
-CIR related to falls with an injury.
-CIR related to a written complaint received alleging neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurse (RPN) and Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s): reviewed resident health records, reviewed falls history reports, reviewed resident quality and safety committee meeting minutes, falls audits, reviewed complaint and investigations, observed a resident and reviewed the following policies: complaints and customer service, falls prevention management and pain identification and management.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 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 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 :

The licensee has failed to ensure that the care set out in the plan for resident #001 related to falls, was provided to resident #001 as specified in the plan, with the use of an alarming device.

The care plan for resident #001 indicated the resident was a risk for falls and the care plan interventions included the use of an alarming device at a specified location. The resident sustained a fall on a specified date and time, complained of pain and had reduced mobility to a specified area. The resident was transferred to hospital the following day and diagnosed with an injury to a specified area. The CIR and the DOC confirmed the alarming device was not in place, at the specified location, at the time of the fall as a fall prevention intervention.

Sources: CIR, resident #001's care plan, post fall assessment and progress notes, DOC interview and risk management report.

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 the care set out in the plan of care, is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that a clinically appropriate pain assessment instrument was used when resident #001's pain was not relieved by initial interventions.

Resident #001 complained of pain to a specified area after sustaining a fall and pain medication was not offered until a number of hours later, which was ineffective and no pain assessment was completed. The following day, the resident continued to complain of pain, the physician was notified and the resident was transferred to hospital, and later diagnosed with an injury to a specified area. The resident was not offered any additional pain medication and no pain assessment was completed at that time. Upon the resident's return from hospital, a new pain medication was ordered and no pain assessment was completed. The DOC confirmed that the electronic pain assessment should have been completed, when the resident sustained an injury with new and worsening pain and when the resident returned from hospital with a new pain medication. Not completing a pain assessment placed the resident at risk for increased discomfort.

Sources: CIR, Pain Identification and Management Policy, resident #001's progress notes, care plan and vitals/pain scale and staff interviews.

2. The licensee has failed to ensure that a clinically appropriate pain assessment instrument was used when resident #002's pain was not relieved by initial interventions.

Resident #002 complained of pain to a specified area during their morning care and reported falling to RN #102. The resident continued to complain of pain to the same area and was not offered pain medication until a number of hours later, which was ineffective. The resident sustained a number of un-witnessed falls the same day, continued to complain of pain to the same area and had decreased mobility. The resident was not offered any additional pain medication and no pain assessment was completed. The following day, the resident continued to complain of pain, the physician was notified, the resident was sent to hospital and diagnosed with an injury to a specified area. No pain medication was offered and no pain assessment was completed at that time. Upon the resident's return from hospital, a new pain medication was ordered and given to the resident and no pain assessment was completed at that time. The following day, the resident's pain had worsened, pain medication was given which was ineffective and a new pain medication was ordered a number of hours later. There was no pain assessment completed at that time. RN #101 and RN #102 confirmed that no pain assessments were completed for the resident when the resident complained of pain after a number of falls resulting in an injury to a specified area or when the resident returned from hospital. The DOC confirmed that no pain assessments were completed for the resident when the resident complained of new pain after a number of falls, had pain that was not relieved with initial interventions, or when the resident returned from hospital with new pain medication.

Sources: CIR, resident #002's progress notes and vitals/pain scales, Pain Identification and Management Policy and staff interviews.

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 when a resident's pain is not relieved by initial interventions, is the resident is reassessed using a clinically appropriate assessment instrument, specifically designed for this purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when resident #002 had fallen, the resident had been assessed using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #002 sustained a number of un-witnessed falls on the same day and during those falls, the resident had a alteration in vital signs, complained of ongoing pain to a specified area, had reduced mobility and was subsequently diagnosed with an injury to the specified area. There were no post-fall assessments completed for a number of the falls that had occurred that day. Staff confirmed that an electronic post-fall assessment should have been completed after each fall, which should provide fall prevention interventions to reduce falls or risk of injury.

Sources: CIR, resident #002's progress notes and care plan, and staff interviews.

Issued on this 5th day of October, 2020

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

Original report signed by the inspector.