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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 14, 2014	2014_202165_0016	L-000663-14	Complaint

Licensee/Titulaire de permis

GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC
704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3

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

GOLDEN YEARS NURSING HOME
704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3

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

TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 12, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nursing staff, Personal Support Workers, the resident and family members.

During the course of the inspection, the inspector(s) reviewed the clinical health record and identified policies and procedures and observed the resident.

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

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 of the long term care home failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.
A) A review of resident #001's clinical health record indicated the resident was experiencing increased pain after a fall. The resident had been receiving routine pain medication and as needed for pain prior to the fall. Four days after the fall staff reported that the routine pain medication was given prior to personal care however, it did not appear to be successful in controlling the resident's pain. It was not until nine days after the fall that a change in pain medication occurred to assist in pain control for the resident. A review of the resident's clinical health record indicated there was no pain assessment completed using a clinically appropriate assessment instrument when the resident's pain was not relieved by initial interventions and the Director of Care verified it was not completed for this resident during this time. [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 to 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that every resident has the right to be properly sheltered, fed clothed, groomed and cared for in a manner consistent with his or her needs fully respected and promoted.
A) Resident #001 sustained a fall. A review of the resident's clinical health record indicated the resident was experiencing increased pain and exhibiting resistive behaviours during personal care. Four days after the fall, documentation indicated that pain medication was provided prior to staff providing personal care however; the resident continued to call out in pain and the medication was not successful in controlling the residents pain. One week later, the home received a phone report that indicated the resident had an injury however; documentation indicated staff would wait for the detailed report and monitor the resident. Two days later, the clinical record indicated the physician on call was faxed indicating the resident had an injury and new orders for pain medication were received, nine days after the resident sustained the fall. The home did not care for the resident in a manner consistent with their needs during this time. [s. 3. (1) 4.]

WN #3: 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. Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.
A) The home's Pain Assessment Program Policy reference number 005300.00 indicated that Registered Nursing Staff would screen the resident at least once a shift during assessments by asking the resident about the presence of pain, ache or discomfort. This assessment would be documented in pain progress note with a summary note written on the last day of seven day observation period.
A review of resident #001's clinical health record indicated that the resident's pain was to be monitored and that a pain progress note every shift for seven days was initiated. A review of progress notes indicated that there was no pain progress note completed for 10 out of the 21 shifts. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The restraining of a resident by a physical device may be included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
A) The plan of care related to falls for resident #001 indicated the resident had a physical device that was used and the resident was capable of removing the physical device when requested. A review of the clinical health record indicated that the physical device was applied and monitored on three identified occasions after the resident sustained a fall. A Personal Support Worker confirmed the resident was not capable of removing their physical device since the fall and when requested by the inspector, the resident attempted however; was unable to remove the physical device. The DOC confirmed that the physical device was currently a restraint for the resident and that there was no physicians order for the use of the physical device. [s. 31. (2) 4.]

Issued on this 14th day of July, 2014

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