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
Direction de l'amélioration de la performance et de la conformité

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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
Aug 22, 2013	2013_201167_0020	H-000215-13	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF HALDIMAND COUNTY
45 Munsee Street, Box 400, Cayuga, ON, N0A-1E0

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

GRANDVIEW LODGE / DUNNVILLE
657 LOCK STREET WEST, DUNNVILLE, ON, N1A-1V9

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

MARILYN TONE (167)

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): July 22, 23, 26, 30, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, registered staff and personal support worker staff, the Resident Assessment Instrument Coordinator (RAI Coordinator), dietary staff and identified residents.

During the course of the inspection, the inspector(s) conducted a review of the health files for identified residents, reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Pain

Personal Support Services

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care for resident # 003 was reviewed and revised when the resident's care needs changed.

A) During a review of the resident's progress notes completed by staff, it was noted that resident # 003 experienced increasing signs and symptoms of pain during the six weeks leading up to their death.
- The resident was noted to be palliative in the Resident Assessment Protocol completed prior to the identified six weeks.
- The physician had written an order for palliative care.
- The document that the home refers to as the care plan dated as last reviewed approximately six weeks prior to the resident's death and confirmed as being the most current care plan by the Resident Assessment Instrument Coordinator was not reviewed and revised to reflect the resident's palliative status nor were there interventions in place related to the management of their palliative care.
- Resident # 003 was noted to be experiencing increasing issues related to pain management over the two months leading up to their death. The document that the home refers to as the care plan for the resident did not identify this pain or the reason for the pain.
- During an interview with the Director of Care, the resident's diagnosis was confirmed in relation to their pain. The resident was not reassessed and there were no revisions made to the care plan to address the changes in the resident's level of comfort.

Resident # 003's plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

2. The licensee did not ensure that the plan of care for resident # 004 was reviewed and revised when the resident's care needs changed.

B) Resident # 004 was noted to have symptoms of possible infection. This problem continued for two months until the resident's physician ordered an antibiotic to treat the condition. At that time the resident had developed a temperature.
- The resident's progress notes completed by staff indicated that the resident began to experience signs of discomfort about nine days prior to their death and their condition continued to deteriorate.
- Six days prior to the resident's death, the resident was exhibiting signs of choking and required suctioning. The resident's oral intake was poor.
- The resident continued to have increasing symptoms of pain and the physician wrote

an order for palliative care and a narcotic analgesic to be administered as required.
- The document that the home refers to as the care plan was not reviewed and revised to include interventions to manage the resident's palliative status or pain management. The care plan related to pain was last reviewed three months prior to their death and indicated that the resident experienced mild pain less than daily.

The resident's plan of care was not reviewed and revised to include their significant change in condition including their presenting symptoms, the change in their level of mobility, recreation participation, toileting ability, physio participation, pain management and did not include the need for suctioning. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee did not ensure that resident # 003 and resident # 004 received end-of-life care in a manner that met their needs.

A) During a review of resident # 003's health file, it was noted in the documentation in the progress notes that the resident was beginning to experience increasing symptoms of pain.
- The documentation in the resident's progress notes also indicated that the resident's family expressed concern about the resident's lack of pain control six times over an identified time frame.
- It was noted in the progress notes that the resident continued to express signs of pain during the months leading up to their death and it was noted on several occasions that the resident's pain was not controlled.
- No pain assessments were completed by staff during this time period.
- In the Resident Assessment Protocol completed by nursing staff approximately 11 weeks prior to their death, it was noted that the resident was to receive palliative care and be kept comfortable but no palliative plan of care was developed or initiated for this resident that included comfort measures and pain control or any identification of the source of the resident's pain.

Resident # 003 did not receive end-of-life care in a manner that met their needs.

B) During a review of resident # 004's health file, it was noted in the documentation in their progress notes that the resident began to exhibit signs of pain on an identified date. These signs and symptoms of pain continued to escalate until the resident's death nine days later.
- The resident's family expressed concern about the resident's lack of pain control four times in the week leading up to the resident's death.
- No palliative plan of care was developed to address the resident's end-of-life care needs related to pain management or other comfort measures.

Resident # 004 did not receive end-of-life care in a manner that met their needs. [s. 42.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 did not ensure that when residents' pain was not relieved by initial interventions that the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) During a review of resident # 003's progress notes completed by nursing staff, it was noted that the resident was experiencing increasing signs and symptoms of pain.
- The home's policy [Pain Management # 25-1.0] directs staff to complete pain assessments on admission, readmission, quarterly and for a significant change in condition.
- Abbey Pain Scale Assessments were completed for resident # 003 prior to this change in the resident's condition and these assessments indicated no pain.
- It had been noted on a three month medication review completed in 2013, that the resident was deemed to be palliative.
- No further Abbey Pain Assessments or pain assessments in the home's electronic documentation system were completed during the period of time leading up to their death two months later.
- The Resident Assessment Instrument Coordinator (RAI Coordinator) confirmed that the assessments for cognitively well residents are completed on the Clinical Pain Assessment in the home's electronic documentation system. For cognitively impaired residents the Abbey Pain Assessment is used.
- During a review of the Resident Assessment Protocol for resident # 003, it was noted that the resident's family member felt that the resident was in pain. The plan was to provide palliative care and to keep the resident comfortable.
- The documentation in the resident's progress notes indicated that the resident's family member expressed concern on several occasions related to the resident's lack of pain control.
- It was noted that the resident continued to consistently exhibit signs of pain. It was noted that the resident received an as required narcotic analgesic 68 times in an identified one month time frame prior to their death.
- No regular doses of this narcotic analgesic were ordered or provided until 10 days prior to their death despite the resident's symptoms of pain.

No pain assessments using a clinically appropriate assessment instrument were completed for resident # 003 during the 11 weeks prior to their death despite the resident's palliative status, repeated documentation related to the resident's discomfort and repeated concerns expressed by family. [s. 52. (2)]

2. During a review of resident # 004's progress notes completed by nursing staff, it was noted that the resident began to exhibit signs of pain on an identified date in 2013. The signs and symptoms of pain continued to escalate until the resident's death nine days later.
- The home's policy [Pain Management # 25-1.0] directs staff to complete pain assessments on admission, readmission, quarterly and for a significant change in condition.
- A Clinical Pain Assessment was completed in the home's electronic documentation system for resident # 004 one week prior to the resident starting to exhibit signs of pain and this assessment indicated no pain.
- There were no further pain assessments completed using the clinically appropriate assessment instrument after that date.
- The Resident Assessment Instrument Coordinator (RAI Coordinator) confirmed that the assessments for cognitively well residents are completed on the Clinical Pain Assessment in the home's electronic documentation system and that there were no other pain assessments completed for resident # 004 after they began to exhibit signs of pain.
- the resident's family expressed concern about the resident's lack of pain control on four occasions in the five days leading up to their death.

Resident # 004 was not reassessed when their pain was not controlled by initial interventions as evidenced by notations in the resident's progress notes and the necessity for family to make staff aware that the resident's pain was not adequately controlled. [s. 52. (2)]

Issued on this 17th day of September, 2013

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

Marilyn Joke

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARILYN TONE (167)
Inspection No. / No de l'inspection :	2013_201167_0020
Log No. / Registre no:	H-000215-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 22, 2013
Licensee / Titulaire de permis :	THE CORPORATION OF HALDIMAND COUNTY 45 Munsee Street, Box 400, Cayuga, ON, N0A-1E0
LTC Home / Foyer de SLD :	GRANDVIEW LODGE / DUNNVILLE 657 LOCK STREET WEST, DUNNVILLE, ON, N1A-1V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOANNE JACKSON

To THE CORPORATION OF HALDIMAND COUNTY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that when residents' care needs change or if the care set out in the plan of care has not been effective that the residents are reassessed and their plans of care reviewed and revised to reflect their current needs.
The plan shall be submitted electronically to marilyn.tone@ontario.ca by September 9, 2013.

Grounds / Motifs :

1. [LTCHA, 2007,S.O.2007,c.8,s.6(10)] Previously issued January 17, 2013 as a WN and August 23, 2013 as a VPC.

The licensee did not ensure that the plan of care for resident # 003 was reviewed and revised when the resident's care needs changed or the care set out in their plan of care was not effective.

A) Resident # 003 was noted to be experiencing increasing symptoms of pain during the two months leading up to their death.
- The resident was noted to be palliative in the Resident Assessment Protocol and the physician had written an order for palliative care.
- The document that the home refers to as the care plan dated as last reviewed prior to this change in the resident's condition and confirmed as being the most current care plan by the Resident Assessment Instrument Coordinator was not

updated to reflect the resident's palliative status nor were there interventions in place related to the management of their palliative care and comfort.

The licensee did not ensure that the plan of care for resident # 004 was reviewed and revised when the resident's care needs changed or the care set out in the plan of care was not effective.

B) Resident # 004 was noted to have had symptoms of infection on an identified date. This problem continued for the next two months until the resident's physician ordered an antibiotic to treat the infection.
- The documentation in the resident's progress notes indicated that the resident began to experience signs of discomfort nine days prior to their death and their condition continued to deteriorate.
- The resident began to exhibit signs of choking and required suctioning.The resident remained in bed due to their weak condition. The resident's oral intake was poor.
- The resident continued to have increasing pain and the physician wrote an order for palliative care and a narcotic analgesic to be administered as required.
- The document that the home refers to as the care plan was not reviewed and revised to include interventions to manage the resident's palliative status or pain management.
The care plan was not updated to include the resident's significant change in condition including identification and management of the new health issues, level of mobility, recreation participation, toileting ability, physio participation, skin breakdown and did not include the need for suctioning.
(167)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the home has a comprehensive program related to end-of -life care in place that includes pain management, comfort measures, staff training and all other aspects of palliative care.
This plan is to be submitted electronically to marilyn.tone@ontario,.ca by September 6, 2013.

Grounds / Motifs :

1. The licensee did not ensure that resident # 003 and resident # 004 received end-of-life care in a manner that met their needs.

A) During a review of resident # 003's health file starting approximately three months prior to the resident's death, it was noted in the documentation in the resident's progress notes completed by nursing staff that the resident was beginning to experience increasing symptoms of pain.
The progress notes also indicated that the resident's family expressed concern about the resident's lack of pain control six times during the months leading up to their death.
- The progress notes completed by nursing staff confirmed that the resident's pain was not controlled.
- In the Resident Assessment Protocol completed by nursing staff 11 weeks prior their death, it was noted that the resident was to receive palliative care and be kept comfortable but no palliative plan of care was developed or initiated for this resident that included comfort measures and pain control.

Resident # 003 did not receive end-of-life care in a manner that met their needs.

B) During a review of resident # 004's health file, it was noted in the documentation in the progress notes that the resident began to exhibit signs of pain on nine days prior to their death. These signs and symptoms of pain continued to escalate until the resident's death.
- The resident's family expressed concern about the resident's lack of pain control four times during this time period.
- No palliative plan of care was developed to address the resident's end-of-life care needs related to pain management or other comfort measures.

Resident # 004 did not receive end-of-life care in a manner that met their needs. (167)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of August, 2013

Signature of Inspector / Signature de l'inspecteur : Marilyn Tone

Name of Inspector / Nom de l'inspecteur : MARILYN TONE

Service Area Office / Bureau régional de services : Hamilton Service Area Office