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 24, 2019	2019_643111_0023	013316-19, 018844-19, 020696-19	Critical Incident System

Licensee/Titulaire de permis

Haliburton Highlands Health Services Corporation
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0

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

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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): November 12 to 15, 21, 25-26, 2019.

The following intakes were completed concurrently during this inspection:
- Log #013316-19 for a critical incident inspection (CIR) related to alleged resident to resident abuse.
- Log #020696-19 for a critical incident inspection (CIR)related to an unexpected death.
- Log #018844-19 for a follow up inspection related to the falls prevention program and pain management program.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Safety Committee Lead, Behavioural Support Ontario (BSO), residents and family.

During the course of the inspection, the inspector: observed resident rooms, reviewed resident health care records, reviewed an investigation, reviewed staff training records, reviewed pain and falls audits and reviewed the following home's policies: pain and symptom management, falls prevention and management, Ordering medications and Oxygen.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Pain
Prevention of Abuse, Neglect and Retaliation

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 48. (1)	CO #001	2019_643111_0014	111

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 :

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A follow up inspection was initiated for compliance order CO #001 that was issued for O. Reg. 79/10, s.48(1) 4, a pain management program to identify pain in residents and manage pain. The compliance date was October 18, 2019. In order to determine compliance with CO #001, three residents were reviewed (resident #001, #003 and #009).

Related to resident #001:

Review of the health care record for resident #001 indicated the resident was admitted on a specified date with no diagnoses related to pain.

Review of the progress notes for resident #001 indicated the resident returned to the home from hospital after a psychiatric leave on a specified date. From the time the resident returned to the home, the resident demonstrated identified responsive behaviours and the home suspected the resident may have been in pain. The resident was administered a combination of narcotic analgesic and anti-anxiety medication a number of times daily, as needed (PRN). A pain scale was completed for each

administration of the analgesic. Because the resident was being administered both medications and at a varied dose, the home would not be able to determine which medication was providing the desired effect. The resident was not offered the regular PRN analgesic, even when the pain level was mild. On a specified date, the resident began to deteriorate. The registered staff and the DOC suspected the resident was over-medicated. The DOC directed staff to hold all medications for one evening to determine if the resident's condition improved and on the following day, the resident's condition improved.

Observation of resident #001 on various dates and times, indicated the resident was not interviewable and was not observed to be in any visible pain or discomfort.

During an interview with the resident's SDM, they indicated to the Inspector that the resident would get restless in the mobility aid since returning from the hospital and the home suspected the resident may have been in pain. The spouse indicated that the staff were giving the resident too much medication, resulting in the resident's condition deteriorating and asked the staff to reduce the medications.

Review of the RAI-MDS for resident #001 completed upon return from hospital indicated under section J, the resident had no pain.

Review of the written plan of care for resident #001 (in place after returning from hospital) related to pain indicated pain was not identified.

Review of the electronic Medication Administration Record (eMAR) for resident #001 for a specified date related to pain medications, indicated the resident was prescribed a number of routine analgesics and a number of PRN analgesics for pain.

Review of the pain assessments for resident #001 indicated the last pain assessment tool was last completed a number of months before the resident was hospitalized, indicated the resident had pain and was unable to indicate location and cause of pain. The pain assessment tool indicated the likely cause of pain was related to a specified pain diagnoses and a specified responsive behaviour. The current pain medication regime included analgesics and the resident had satisfactory pain management. There were no other pain assessment tools completed when the resident returned from hospital.

During separate interviews with RN #100 and RN #101, they indicated that when a

resident has pain, their care plan should be updated to indicate where the pain was located, what caused the pain and interventions used to manage the pain. The RN confirmed that resident #001 had a number of routine and PRN analgesics currently in use and has had changes to their analgesics since return from hospital. The RN indicated the residents was unable to describe their pain. The RN confirmed the resident's care plan did not provide clear directions to staff related to pain.

During an interview with the DOC, they confirmed that resident #001 had pain but unable to indicate where the pain was, received a number of analgesics routinely and as PRN. The DOC indicated no awareness that the resident's care plan had no clear directions in the plan of care related to pain and should have.

The licensee had failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #001 related to pain.

2.Related to resident #003:

A Critical Incident Report (CIR) was submitted to the Director on a specified date for an unexpected death.

Review of the progress notes for resident #003 indicated on a specified date and time, the resident was complaining of feeling unwell and have signs and symptoms of shortness of breath (SOB). The resident continued to have SOB and was sent to hospital for assessment and diagnosed with a specified illness. The resident returned from the hospital later the same day with new medications and instructions ordered related to SOB. The following day, the resident continued to experience SOB and the interventions related to SOB were not implemented. The resident was later found without vital signs.

Review of the current written plan of care for resident #003 indicated the resident was admitted on a specified date with a specified diagnoses that required the use of a specified therapy. There was no direction in the plan related to the use of the specified therapy.

Review of the physician orders and medical directives for resident #003 indicated there was no order in place for the use of the specified therapy when the resident was admitted or when the resident returned from hospital.

During an interview with RN #101, they indicated resident #003 was receiving the

specified therapy since admission at a specified dose. The RN indicated there should be a physician's order for the specified therapy and was not aware there was no physician's order for the use of the specified therapy. The RN confirmed they were working when resident #003 passed away. The RN confirmed they noted the resident had SOB, had the specified therapy in use and the resident reported they only had SOB on exertion. The RN confirmed the resident's SOB increased and did not inform the physician.

During an interview with RN #100, they indicated that there should be a physician's order in place for residents with the specified therapy in use. The RN confirmed that resident #003 was using the specified therapy since admission and had no awareness that there was no physician's order in place.

During an interview with the Physician, they indicated there should be a physician order in place for resident's using the specified therapy. The Physician indicated awareness that resident #003 was using the specified therapy, but was unaware that there was no physician order in place for the use of the specified therapy.

During an interview with the DOC, they confirmed that the specified therapy was a drug and that there should be a physician's order in place for resident 's with the specified therapy in use. The DOC indicated awareness that resident #003 was using the specified therapy since admission, but was not aware that there was no physician's order in place.

The licensee had failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #003 related to the use of the specified therapy.

3. Related to resident #009:

Review of the health record for resident #009 indicated the resident was admitted on a specified date, with diagnoses that required the use of the specified therapy. The resident had no physicians order in place regarding the use of the specified therapy.

Review of the eMAR for resident #009 for a specified date, indicated the resident was to receive the specified therapy at a specified dose and time. The order was received before the resident was admitted.

Review of the current written plan of care for resident #009 had no direction in the plan related to the use of the specified therapy.

During an interview with the DOC, they indicated that resident #009 was previously admitted as a respite, discharged and then re-admitted as a permanent resident on a specified date and should have had a new physicians order in place for the specified therapy.

During an interview with RN #100, they confirmed that resident #009 used the specified therapy during a specified time and at a specified rate. The RN confirmed that there was no physicians order for the use of the specified therapy.

The Physician indicated awareness that resident #009 was using the specified therapy but was unaware that there was no physician order in place for the use of the specified therapy.

The licensee had failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident #009 related to the use of the specified therapy.

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time, when the resident's care needs changed or care set out in the plan was no longer necessary.

A follow up inspection was initiated for compliance order CO #001 that was issued for O. Reg. 79/10, s.48(1) 1, a falls prevention and management program developed and implemented in the home to reduce the incidences of falls and reduce the risk of injury. The compliance date was October 18, 2019.

Related to resident #008:

Review of the progress notes and pain scale assessments for resident #008 indicated the resident had sustained a fall on a specified date, resulting in pain to a specified area and was transferred to hospital. The resident was diagnosed with a specified injury to a specified area. The resident returned from the hospital on a specified date and had daily, moderate pain to a specified area. The resident's condition continued to deteriorate and the resident later passed away.

Review of the current written plan of care for resident #008 indicated the resident had pain related to a specified diagnosis and history of falls. There were a number of

identified interventions. The plan of care was not revised when the resident returned from hospital with an injury to a specified area or when the resident became palliative.

During an interview with the DOC, they confirmed that resident #008 had new pain to a specified area upon return from hospital after sustaining an injury to a specified area. The DOC confirmed the resident was receiving a number of analgesics and the resident became palliative on a specified date. The DOC confirmed that resident #008's plan of care was not revised related to new pain or palliation and should have been.

The licensee failed to ensure the plan of care was reviewed and revised when resident #008's care needs changed related to pain (sustained an injury to a specified area and palliation).

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 plan of care sets out clear directions to staff and others who provide direct care to the resident, related to the use of oxygen; to ensure the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time, when the resident's care needs changed or care set out in the plan is no longer necessary, 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 when the resident's pain is not relieved by initial

interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A follow up inspection was initiated for compliance order CO #001 that was issued for O. Reg. 79/10, s.48(1) 4, a pain management program to identify pain in residents and manage pain. The compliance date was October 18, 2019.

Related to resident #001:

During an interview with the DOC, they indicated the home's clinically appropriate assessment tool to be used for assessing pain was the pain assessment tool on Point Click Care (PCC).

Review of the health care record for resident #001 indicated the resident was re-admitted from hospital on a specified date. The progress notes and pain scale assessments for resident #001 indicated the resident was administered narcotic analgesics a number of times daily as a PRN for responsive behaviours that the home suspected was a result of pain. On a specified date, the resident began to deteriorate and the DOC suspected the resident was over-medicated. The DOC directed staff to hold all medications (including analgesics) for a specified period, to determine if the resident's condition improved. The following day, the resident’s condition improved.

Review of the electronic Medication Administration Record (eMAR) for resident #001 for a specified date, related to pain medications, indicated the resident was prescribed a number of routine and PRN analgesics.

Review of the pain assessments for resident #001 indicated the last pain assessment tool was last completed a number of months before the resident was re-admitted from hospital. There were no other pain assessment tools completed when the resident returned from hospital, despite the staff administering a number of PRN analgesics.

During an interview with RN #101, they indicated when a resident was experiencing pain, they used an electronic pain scale, to determine the resident’s level of pain, provide the ordered analgesic and then reassess the resident's level of pain afterwards to determine the effectiveness. The RN indicated they also completed the electronic pain assessment tool upon a resident’s admission, quarterly and if there is a change in the resident's pain or new pain. The RN confirmed resident #001 had returned from hospital on a specified date, had a number of routine and PRN analgesics administered for pain, had recent

changes to their analgesics and there was no pain assessment tool completed for resident #001, upon return from hospital.

During an interview with RN #100, they indicated that when a resident has pain, they complete an assessment of the resident using the electronic pain scale, administer analgesic and then reassess the resident's pain after to determine if it was effective. The RN indicated they also complete the electronic pain assessment tool on admission and quarterly. The RN indicated they would complete a paper 24hr pain and symptom monitoring tool if the resident develops new pain or has pain that is not relieved. The RN confirmed that resident #001 had a number of routine and PRN analgesics currently in use for pain and had changes to their analgesics since return from hospital. The RN indicated the pain assessment tool was last completed a number of months before the resident was admitted to hospital, there was no 24 hr pain and symptom monitoring tool completed for the resident and both should have had been completed upon return from hospital.

During an interview with the DOC, they indicated when the resident has pain, the registered staff are to complete the pain scale assessment before and after analgesic is given. The DOC indicated that if the pain was not relieved by initial interventions, then the pain assessment tool should be completed to ensure the resident has adequate and appropriate pain control. The DOC confirmed no awareness of a pain and symptom monitoring tool and confirmed that resident #001 did not have a pain assessment tool completed upon return from hospital with suspected pain.

The licensee failed to ensure that when resident #001's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument (pain assessment tool).

2. Related to resident #008:

Review of the health care record for resident #008 indicated the resident was admitted on a specified date with diagnoses that included a previous injury to a specified area. The progress notes and pain scale assessments for resident #008 indicated the resident had sustained a number of falls over a specified period, with the last fall resulting in transfer to hospital. The resident returned from the hospital on a specified date with an injury to a specified area and had pain as a result. The resident's condition continued to deteriorate and passed away a number of days later.

Review of the electronic Medication Administration Record (eMAR) for resident #008 for a specified date, related to pain medications, indicated the resident was prescribed a number of analgesics.

Review of the current RAI-MDS for resident #008 indicated under section J, Health Conditions: no pain. There was no assessment completed upon the resident's return from hospital.

A pain assessment tool was completed for resident #008 on a specified date, indicated the resident was unable to indicate the location or characteristics of pain and denied any pain. The tool indicated the pain was likely caused by a specified diagnosis and located in a specified area. The tool indicated the behaviours were unrelated to pain. There were no other pain assessments completed after the resident returned from hospital with an injury to a specified area, or when the resident was deemed palliative.

During an interview with RN #100, they confirmed that resident #008 had gone to hospital and returned on a specified date with an injury to a specified area and had pain. The RN confirmed the residents did not have a pain assessment tool completed upon return from hospital. The RN confirmed the resident was deemed palliative a short time later and did not have a pain assessment tool completed at that time and should have had been completed.

During an interview with the DOC, they indicated when the resident has pain not relieved by initial interventions, then the pain assessment tool should be completed to ensure the resident has adequate and appropriate pain control. The DOC confirmed resident #008 had no pain assessment tool was completed upon return from hospital with an injury, when the resident had pain, or when the resident was deemed palliative.

The licensee failed to ensure that when resident #008’s pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument (pain assessment tool).

3. Related to Resident #005:

Observation of resident #005 on a specified date and time by the Inspector, indicated the resident was independently mobile with the use of a mobility aid and was in visible pain. The resident was asked if they had any pain and confirmed they were in constant pain to specified areas. The resident indicated they received analgesics for pain control and did

"help a little".

Review of the current written plan of care for resident #005 related to pain indicated the resident had pain related to a specified diagnosis and had a number of identified interventions.

Review of the current RAI-MDS for resident #005 indicated under section J, Health Conditions: moderate pain less than daily, in specified areas.

Review of the pain assessment tools for resident #005 indicated the last pain assessment was completed on a specified date, indicated the resident had daily moderate pain to specified areas. There were no other pain assessments completed.

During an interview with RN #101 by the Inspector, they indicated resident #005 had chronic pain in specified areas. The RN indicated the resident received analgesic ointment for a specified area and received a specified analgesic, at specified times and as needed (PRN). The RN indicated the residents pain is assessed using the pain scale to determine the residents level of pain, then they provide the analgesic as ordered and then reassess the resident's level of pain afterwards to determine the effectiveness. The RN indicated the electronic pain assessment tool is the home's comprehensive pain assessment instrument and is only completed on admission and quarterly.

Review of the electronic Medication Administration Record (eMAR) for a specified date, for resident #005 related to pain, indicated the resident had a number of analgesics.

During an interview with the DOC, they indicated the staff are to complete the pain assessment tool in PCC on admission and quarterly. The DOC indicated when the resident has pain, the registered staff are to complete the pain scale assessment before and after analgesic is given, as per the home's pain policy to determine effectiveness of the intervention. The DOC indicated the expectation is that the registered staff are to update the care plan related to pain to include location of pain, what causes the pain, what relieves the pain (both pharmacological and non-pharmacological) and assessments to be completed. The DOC confirmed that resident #005's written plan of care did not provide clear direction to staff related to their pain.

The licensee had failed to ensure that when resident #005's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument (pain assessment tool).

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 the 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.

Issued on this 9th day of January, 2020

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

Original report signed by the inspector.