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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 12, 2018	2018_678680_0002	028142-17	Resident Quality Inspection

Licensee/Titulaire de permis

Corporation of the County of Grey
595 9th Avenue East OWEN SOUND ON N4K 3E3

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

Lee Manor Home
875 Sixth Street East OWEN SOUND ON N4K 5W5

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

TRACY RICHARDSON (680), DOROTHY GINTHER (568), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): January 11, 15, 16, 17, 18 and 19, 2018.

The following Critical Incident Intakes were inspected concurrently during the Resident Quality Inspection:
Log #018712-16, Critical Incident #M549-000004-16, related to alleged staff to resident abuse
Log #024845-16, Critical Incident #M549-000007-16, related to alleged staff to resident abuse

Log #029320-16, Critical Incident #M549-000010-16, related to an unexpected death
Log #030895-16, Critical Incident #M549-000011-16, related to an alleged intruder
Log #034246-16, Critical Incident #M549-000015-16, related to a missing narcotic
Log #000097-17, Critical Incident #M549-000016-16, related to a missing narcotic
Log #005718-17, Critical Incident #M549-000006-17, related to alleged resident to resident abuse
Log #012418-17, Critical Incident #M549-000011-17, related to a missing narcotic
Log #013883-17, Critical Incident #M549-000013-17, related to a missing narcotic
Log #018144-17, Critical Incident #M549-000014-17, related to falls prevention and management
Log #021637-17, Critical Incident #M549-000016-17, related to a missing narcotic
Log #022615-17, Critical Incident #M549-000017-17, related to a missing narcotic

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Assistant Director of Care, Resident and Family Services Manager, Dietary Manager, Registered Dietitian, Pharmacy Technician, Registered Practical Nurses, Registered Nurses, Personal Support Workers, Food Service Worker, Physiotherapist, Residents' Council Representative, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care, and the general maintenance and cleanliness of the home. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident and staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care information and inspection reports.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **6 WN(s)**
- **4 VPC(s)**
- **2 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	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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Ontario Regulation 79/10, s. 50 (3) defines altered skin integrity "as the potential or actual disruption of epidermal or dermal tissue."

A) Review of a specified resident's clinical record identified that on a specific date the resident had an un-witnessed fall. The fall note stated that the resident was found beside the bed. There was a suspected injury to an area of the body. A progress note on a specific date documented that the resident presented with altered skin integrity.

Review of a progress note on a specific date for the resident documented that there was a alteration to the resident's skin integrity. The resident denied pain and stated that the altered skin integrity was related to the fall. A progress note, documented that the resident continued to complain of increasing pain with weight bearing during a type of activity of daily living. Assessment of the area mentioned an altered skin integrity that was older. Assessment of the remainder of the body found the specific alteration in skin integrity was present, which the resident stated was from the fall.

During a review of the resident's clinical record there was no evidence that a skin assessment was conducted in relation to the resident's altered skin integrity as identified in the progress notes.

During an interview with a registered staff member they shared that when a new area of skin concern was identified the registered staff would complete an assessment using the Skin/Wound Care assessment tool on Point Click Care (PCC). The treatment plan for that skin concern would be documented in the Treatment Administration Record (TAR) on PCC. These assessments would be conducted for all types of skin concerns. When asked the registered staff member recalled assessing the specified resident after their fall, the registered staff member said they were off work at the time of the fall. When they returned, the registered staff member stated that the specific resident was having a pain in a specific area. When asked if they recalled seeing any alteration in skin integrity, the registered staff member said they believed the resident had a specific area of altered skin integrity.

In an interview with the ADOC said that there should have been an assessment of the identified altered skin integrity and acknowledged that there were no skin assessments completed.

B) Review of another resident's progress notes identified a post fall note on a specified date, which stated that the resident was found on the floor. The resident had an injury and there was altered skin integrity. A progress note, stated that the resident had a specified alteration in their skin integrity.

During an interview with a registered staff member they shared that when a new skin concern was identified the registered staff would complete an assessment using the Skin/Wound Care assessment tool on Point Click Care (PCC). The treatment plan for that skin concern would be documented in the Treatment Administration Record (TAR) or PCC. These assessments would be conducted for all types of skin concerns including skin tears, lacerations, bruises and wounds.

Upon review of the resident's clinical record there was no evidence that a Skin/Wound Care assessment had been completed for the resident's altered skin integrity which were sustained as a result of the fall.

In an interview with the ADOC, they shared that Skin / Wound Care assessments should

be conducted for all areas of altered skin integrity including skin tears, lacerations and wounds. In terms of bruises, staff may not be completing a Skin/Wound Care assessment but should be documenting a skin observation note in the progress notes on PCC. After reviewing the specific resident's clinical record the ADOC acknowledged that there were no skin assessments for the resident's altered skin integrity. The ADOC agreed that the specific injury was altered skin integrity based on the definition within the Long-Term Homes Regulations, and as such, it should be assessed using a clinically appropriate assessment instrument designed for skin and wound assessment.

C) Review of another resident's progress notes identified a post fall note on a specific date, which stated that the resident had an un-witnessed fall in which they sustained an area of altered skin integrity.

During an interview with the registered staff member they shared that when a new skin concern was identified the registered staff were to complete an assessment using the Skin/Wound Care assessment tool on Point Click Care (PCC). The treatment plan for that skin concern would be documented in the Treatment Administration Record (TAR) on PCC. These assessments would be conducted for all types of skin concerns including skin tears, lacerations, bruises and wounds.

Upon review of the resident's clinical record there was no evidence that an initial Skin/Wound Care assessment was completed for the resident's altered skin integrity.

During an interview the Assistant Director of Care (ADOC) said that it was the home's expectation that areas of altered skin integrity including wounds, lacerations and skin tears would be assessed by registered staff using their Skin/Wound Care assessment on PCC. After reviewing the specific resident's clinical record, the ADOC acknowledged that the home had not completed an initial assessment of both the altered skin integrity following their fall.

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a

registered dietitian who was a member of the staff of the home.

Review of a specific resident's progress notes identified that the resident fell and sustained a change to their skin integrity. A progress note, stated that the resident had an area of altered skin integrity.

During an interview with the Registered Dietitian (RD) they said that it was the home's practice to refer residents who exhibited a new skin concern to the RD for an assessment. This would include abrasions, skin tears, lacerations, and wounds. When asked if a referral would be made to the RD for a specific type of skin change, the RD said that this was not the home's current practice unless there was a specific concern.

Upon review of the residents' clinical record there was no evidence that a RD had assessed the resident in relation to the altered skin integrity.

In an interview the ADOC said that it was not the home's practice to send a referral to the RD for that specific type of altered skin integrity , and acknowledged that there was no assessment by the RD for the resident in relation to those alterations.

The licensee failed to ensure that the specified resident was assessed by a registered dietitian who was a member of the staff of the home in relation to their altered skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Review of a specific resident's clinical record identified that the resident had an un-witnessed fall. There was a suspected injury as the resident reported pain, but there was no change to the resident's skin integrity. A progress note on a date documented that the resident presented with an alteration to their skin integrity. A progress note documented the altered skin integrity was noted on the resident. The resident denied pain and stated that the alteration of their skin integrity was related to the previous fall. A progress note documented that the resident continued to complain of increasing pain. Assessment of the resident's identified injury noted the resident's altered skin integrity. Assessment of the remainder of the resident's body found alterations to the resident's skin integrity which the resident stated was from the fall.

During a review of the resident's clinical record there was no evidence of a weekly skin assessment in relation to the altered skin integrity as identified in the progress notes.

In an interview with a registered staff member they shared that when a new skin concern was identified the registered staff would complete an assessment using the Skin/Wound Care assessment tool on Point Click Care (PCC). Weekly thereafter the registered staff would reassess the skin concern using the Skin/Wound Care assessment tool. These assessments should be conducted for all types of skin concerns including skin tears, lacerations, bruises and wounds.

In an interview with the ADOC, they said that it was the home's expectation that staff reassess all types of skin concerns, including the specific change in skin integrity on a weekly basis until they resolved. They may not document on the Skin/Wound Care assessment form, but at a minimum there should be a structured skin observation note in PCC under the progress notes.

After reviewing the resident's clinical record, the ADOC acknowledged that there were no weekly skin assessments completed in relation to the resident's altered skin integrity.

B) Review of another resident's progress notes identified a post fall note on a specific date, which stated that the resident had fallen and sustained an injury with an alteration in skin integrity.

Upon review of the resident's clinical record there was no evidence that weekly Skin/Wound Care assessments had been completed for the resident's altered skin integrity which were sustained as a result of the fall.

During an interview with a registered staff member they shared that when a new area of skin concern was identified the registered staff would complete an assessment using the Skin / Wound Care assessment tool on Point Click Care (PCC). They would then complete weekly Skin / Wound Care assessments of the identified skin concerns until they were resolved. These assessments should be conducted for all types of skin concerns including skin tears, lacerations, bruises and wounds.

In an interview with the ADOC said that it was the home's expectation that staff reassess all types of skin concerns, including the specific change in skin integrity on a weekly basis until they resolved. They may not document on the Skin/Wound Care assessment form, but at a minimum there should be a structured skin observation note in PCC under

the progress notes.

After reviewing the resident's clinical record, the ADOC acknowledged that there were no weekly skin assessments completed in relation to the resident's altered skin integrity.

C) Review of another resident's progress notes identified a post fall note on a specific date, which stated that the resident had an un-witnessed fall. The post fall note stated that as a result of the fall the resident sustained an injury and had altered skin integrity.

During an interview with a registered staff member they shared that when a new skin concern was identified the registered staff were to complete an assessment using the Skin / Wound Care assessment tool on Point Click Care (PCC). The treatment plan for that skin concern would be documented in the Treatment Administration Record (TAR) or PCC. These assessments should be conducted for all types of skin concerns including skin tears, lacerations, bruises and wounds.

Upon review of the resident's clinical record there was no evidence that the resident's altered skin integrity were reassessed weekly.

During an interview with the Assistant Director of Care (ADOC), they said that it was the home's expectation that areas of altered skin integrity would be reassessed at least weekly by registered staff using their Skin / Wound Care assessment on PCC. The ADOC acknowledged that the home had not reassessed the resident's altered skin integrity.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 history of one or more related non-compliance with this section of the Act that included: voluntary plan of correction issued on October 17, 2016, during a critical incident inspection #2016_448155_0016, voluntary plan of correction issued on January 18, 2018 #2017_678680_0024. [s. 50. (2) (b) (iv)]

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. 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 has 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.

Review of a specified resident's clinical record identified a fall note on a specific date, which stated that the resident had been found on the floor. There was a suspected injury as the resident claimed pain in the same area. Progress notes from a specific date and time to another date and time which was 23 days later, showed that the resident had been experiencing pain and was receiving analgesic for that specified pain related to injury incurred at the time of the fall.

The electronic Medication Administration Record (eMAR) identified that the resident had an order for a specific analgesic at a specific time. It was documented that the resident received this medication. The eMAR also documented an order for different analgesic to be given every four hours as needed (PRN). It was documented that the resident received that analgesic on 10 occasions during a specific time frame. There was no evidence that a pain assessment was conducted for the resident during the time they fell and when the doctor assessed them.

During an interview with a Personal Support Worker (PSW) and registered staff member they said that prior to the resident's fall, the resident was very independent. After the fall, the resident had reported increasing pain which limited their ability to walk. Instead they

required assistance with a device to go the dining room. The resident required more assistance with their activities of daily living. The registered staff member shared that prior to the fall the resident rarely complained of pain and never asked for extra medication.

The home's policy VII-G-30.10 titled "Pain & symptom Management" approved and revised December 2015, stated under the "Procedure" that registered staff would conduct and document a pain assessment electronically on initiation of a pain medication or as needed analgesic, when there was a change in condition with pain onset, when a resident reported pain or symptoms of greater than four on a numerical ten point scale for 24 to 48 hours.

In an interview the Assistant Director of Care (ADOC) said that given the resident's fall, the onset of a new pain, and the administration of as needed (PRN) medication for pain, it would be the home's expectation that a pain assessment be conducted using their Pain Assessment V4 tool on Point Click Care (PCC). the ADOC acknowledged that the resident did not have a pain assessment when initial interventions did not relieve their pain. [s. 52. (2)]

2. Review of another resident's clinical record identified that the resident had three un-witnessed falls in an identified month, over a three day period. As a result of one of the falls the resident sustained an injury and had altered skin integrity.

During an interview with a PSW they said that the resident reported pain on almost a daily basis to specific areas of their body. The resident would usually go to the nurse when they were uncomfortable and needed medication. The PSW said that the resident did not always tell them they had pain, but it was evident in other ways such as withdrawal from activities and the need for more assistance with their activities of daily living.

In an interview with the specific resident, they shared that they experienced pain on almost a daily basis to specified areas of their body. The resident said that their pain had worsened and they were having to take more medication to control the symptoms. They were unsure as to why the pain worsened but said they had a number of falls which may have contributed to it. Their physician had just recently changed their medication to help with better pain control.

The electronic Medication Administration Record (eMAR) for a certain month

documented that the resident received their regularly scheduled analgesic three times a day as ordered for pain control. In addition, the resident received an as needed (PRN) dose of analgesic a specific amount of times during the specified month. It was noted that when the PRN medication was given the resident's pain level was assessed using a numerical pain scale which ranged between five and eight out of ten. There was no further assessment of the pain in terms of its location, frequency and quality. In two specific months, the eMAR documented that the resident received a PRN dose of analagesic a specified number of times in each of the months. Pain levels were documented using the numerical pain scale and ranged between five and nine out of ten.

In an interview a registered staff member shared that the resident had chronic pain to specific areas of their body. The resident had a number of falls in the last quarter and their pain seemed to have increased. During the three month medication review, it was noted that the resident was being given more PRN analgesics and the physician had made some medication changes to provide for better pain control. On a specific date, the physician ordered an increase of a specified analgesic.

During a review of the residents clinical record there was no evidence that the resident's pain had been assessed beyond the numerical pain scales documented at the time that the PRN medication was given.

The home's policy VII-G-30.10 titled "Pain & Symptom Management" approved and revised December 2015, stated under the "Procedure" that registered staff would conduct and document a pain assessment electronically on initiation of a pain medication or PRN analgesic, when there were behaviours exhibited by a resident that may be an indicator for the onset of pain, when a resident reported pain or symptoms of greater than 4/10 for 24-48 hours, when they received pain medication for greater than 72 hours.

In an interview the ADOC said they agreed that the resident should have had a full pain assessment conducted using the Pain Assessment V4 tool on PCC given that the resident's pain had not being relieved by initial interventions and PRN analgesics were being given at an increased frequency to manage symptoms. [s. 52. (2)]

3. In a review of another resident's plan of care it was noted that the resident experienced pain to specific areas of their body. On a specified date a Physiotherapy Assessment Note stated that the resident was still complaining of a specific type of pain that radiated. At that time the pain was rated four out of a possible ten on the numerical pain scale. The assessment stated that there had been no improvement in pain from the

last quarter.

In an interview with the resident they shared that they experienced pain to specific areas of their body, some days worse than others. The resident stated that they took medication to help control the pain but some days it was not enough. On those occasions they would ask the nurse for extra medication. The resident said that more recently the pain had been worse but they didn't know why.

The electronic Medication Administration Record (eMAR) documented the medication orders and administration for the period of one specific month. The eMAR documented the date of the order and the administration of the medication that had been given.

During an interview the PSW said that lately the resident had been exhibiting more signs of pain to a specific area of their body. Sometimes the resident would tell them about the pain and other times it was evident by the way the resident was performing an activity of daily living. A registered staff member told the inspector that the resident had chronic pain to certain areas of their body. The resident was not someone who liked to ask for pills but they could tell when the pain worsened because they became quiet and withdrawn. They would also have a lot of difficulty performing a specific activity of daily living. The registered staff member said that the physician had recently increased resident's pain medication because it was found they were taking more of the PRN medications.

Physician notes and orders on a specific date, stated that the resident had pain. New orders for increase to a specific medication in the morning, at noon and before bed. A specific analgesic was increased to a specified amount daily.

During a review of the resident's clinical record there was no evidence that the resident had a pain assessment completed in the last six months.

The home's policy VII-G-30.10 titled "Pain & Symptom Management" approved and revised December 2015, stated under the "Procedure" that registered staff would conduct and document a pain assessment electronically on initiation of a pain medication or PRN analgesic, when there were behaviours exhibited by a resident that may be an indicator for the onset of pain, when a resident reported pain or symptoms of greater than four out of ten for 24-48 hours, when they received pain medication for greater than 72 hours.

In an interview the ADOC said they agreed that the resident should have had a full pain assessment conducted using the Pain Assessment V4 tool on PCC given that the resident's pain was not being relieved by initial interventions and PRN analgesics were being given at an increased frequency to manage symptoms.

The licensee has 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.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 history of one or more related non-compliance with this section of the Act that included: voluntary plan of correction issued on January 18, 2018 #2017_678680_0024. [s. 52. (2)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding alleged staff to resident abuse.

The CIS related to alleged rough handling of a specific resident. The CIS stated that

during the investigation into the incident one staff member had reported the incident.

Review of the home's policy titled "Prevention of Abuse and Neglect of a Resident," dated scheduled for revision October 2017, was completed. The policy stated "If any employee or volunteer witnesses an incident, or has knowledge of an incident, that constitutes resident abuse or neglect, all staff are responsible to immediately take these steps:
1. STOP the abuse situation and intervene immediately if safe for them to do so while ensuring the safety of the resident."
"The policy stated that physical abuse is defined as:
d) Any undue physical force by a staff member when providing care to a resident."

In an interview a Personal Support Worker (PSW) shared that they had completed the care with another PSW and had reported the incident to the charge nurse as being abusive. The PSW shared that the other PSW was very rough during the care. The PSW stated that the residents were calm prior to care and then showed signs that they did not want the care being provided.

In an interview with a registered staff member they stated that if a resident was exhibiting signs that they did not want care, staff would wait and try again.

In an interview a PSW stated if a resident was showing signs that they did not want the care, you would leave and re-approach.

In an interview the Director of Care (DOC) stated that resident's should not be treated in a disrespectful manner. The DOC shared that they have consistently taught staff about the position of power.

B) Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding alleged staff to resident abuse.

The CIS related to alleged rough handling of another resident. The CIS documented that during the investigation into the incident a witness reported that a specific PSW did not explain to the resident any procedure prior to initiating it, and was not providing care in a manner consistent with the policy. The CIS further stated that the residents were showing signs of not wanting the care provided.

In an interview on a specific Personal Support Worker (PSW) shared that they had

completed the care with another PSW and had reported the incident to the charge nurse. The PSW shared that the other PSW was very rough when administering care.

In an interview with a registered staff member they shared that there is no reason for being rough during care.

Another PSW stated if a resident did not want the care you were providing you would leave and return to try again. The PSW stated that staff would never be rough with a resident and that would be unacceptable.

In an interview the Director of Care (DOC) stated that using undue force is not acceptable and should never happen.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

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 written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: 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 :

1. The licensee has failed to ensure that when a resident had fallen, the resident was

assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of a specific resident's clinical record identified a progress note which stated that the resident had a fall. The fall was un-witnessed. There was a suspected injury as the resident claimed pain in this area. The physician was not notified and they were unable to reach the Power of Attorney (POA) at that time. A progress note titled "Post Fall Assessment Note" stated that the resident had a fall. The progress note went on to describe the fall and onset of pain soon after. The "Action" section of the notes stated that a mobile x-ray had been taken on a specific date, which determined that the resident had sustained an injury that required a transfer to the hospital.

In an interview the Director of Care (DOC) told the Inspector that post-fall the registered staff completed a Risk Management Assessment and part of this assessment would push to the progress notes. The assessment included a review of the fall, assessment details, contributing factors and actions. In addition, the Registered Nurse would complete a Post Fall Assessment Note in the progress notes which acted as a summary of the fall and would include the outcome. This was done within 24 to 48 hours of the fall.

The home's policy VII-G-30.00 titled "Falls Prevention" approved and revised December 2015, stated under the section "Post Falls Assessment" that registered staff would complete a thorough investigation of the fall incident including all contributing factors, complete an electronic post fall assessment by using the Post Fall Huddle or Fall Incident Report.

During a review of the resident s clinical record there was no evidence of a post fall assessment for this specific fall, which included a thorough investigation of the fall including all contributing factors.

The DOC acknowledged that there was no post fall assessment completed for the resident's fall on a specified date, using a clinically appropriate assessment instrument designed for falls.

The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (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 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A) Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding a missing narcotic medication for a specific resident.

Review of the CIS showed they could not find the previously specified medication that had been recorded as being present. The CIS also stated that the medication had last been administered on a date prior to this date.

Review of the doctor's orders for the specific resident in PCC showed that the medication was to be administered at specific time intervals.

Review of the homes specific report regarding missing medication and was for the specified resident it stated that the medication was last given the day before.

Review of the progress note for the resident on a specific date, stated unable to locate the previous medication and that the resident was administered the medication from a stat box supply within the home. There was no documentation to support that the doctor had been notified for a new order to change the times in which the medication was to be administered.

Review of the doctors orders did not show that a doctor had ordered the change in schedule following the missing medication.

B) Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding a missing medication for a specific resident.

Review of the CIS showed they could not find the previously specified medication that had been recorded as being present. The CIS also stated that the medication had last been administered on a date prior to this date.

Progress note stated that the medication was checked in the morning and that another dose of medication was given later when found missing.

Progress note stated that they were unable to find the medication and that another one had been administered and the administration time changed on MAR. There was no documentation to support that the doctor had been notified for a new order to change the time frame of the medication.

Review of the doctors orders did not show that a doctor had ordered a time change for that specific medication following the missing report. Review of doctor's order in PCC stated the time frames that the medication was to be administered.

Review of the homes specific report regarding missing medications for the resident stated that the medication was administered on one date and the date it was to be administered was the not the same date.

C) Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding a missing medication for another resident.

Review of the CIS stated they were unable to locate the medication.

Progress note for the resident on a specific date and time stated that the medication had been administered on a different date than prescribed. There was no documentation to support that the doctor had been notified for a new order to change the time of the medication.

Review of the doctors orders for the resident did not show that a doctor had ordered the change in the schedule following the missing medication.

Review of the homes missing medication report for the resident, showed that the medication was not scheduled to be administered that day and that the medication had been administered.

A registered staff member stated that when a specific medication went missing the doctor was notified by fax or secure messaging by the registered nurse (RN).

A registered staff member stated that when a specified medication went missing they placed it in the doctor's communication book but that they do not normally call the doctor as the direction would be to replace the medication and monitor the resident for specific symptoms. The registered staff member shared that they did not call the doctor to discuss changing the time frame of the medication when they found one missing. The registered staff member stated that they called the pharmacy and then changed the electronic Medication Administration Record (eMAR) to change the scheduled times of the medication.

Review of the secured text message from the Physician stated that when this specified type of medication is lost they would prefer if the physician is informed in the morning (am) or evening (pm) about it. Administering the medication is acceptable as long as the physician knows. The Physician gave an explanation as to why it was important to notify them before changing the schedule.

The Director of Care (DOC) stated that there was no order allowing the nurses to administer the medication early, and no documentation to support the doctor had been notified to change the scheduled times for the medication. The DOC shared that the doctor was in and out frequently and they were certain that the doctor would be aware. The DOC acknowledged that there was no documentation to support that the change in direction was ordered by a doctor.

The licensee has failed to ensure that drugs were administered to a resident in

accordance with the directions for use specified by the prescriber. [s. 131. (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 o ensure that drugs are administered to a resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

The Long-Term Care Homes Act. 2007, S.O. 2007, c.8 s.86 (2) (b) states "The licensee shall ensure the infection prevention and control program must include measures to prevent the transmission of infections."

During the Resident Quality Inspection (RQI), the inspector entered a specific resident room. Upon exiting the room to request assistance for the resident, a Personal Support Worker (PSW) entered the room and donned gloves. When exiting resident's room the PSW informed the inspector that the resident was on isolation precautions. There was no signage on the resident room, outside the room was a station with gowns, gloves.The PSW acknowledged that there was no sign on the door. Observation the next day showed that there was a droplet precaution sign posted on resident's room door.

A registered staff member acknowledged that there was no sign on the door and that the resident was on respiratory isolation. The registered staff member shared that the sign

was normally on the door and staff were notified at the beginning of their shift.

Review of the home's policy titled "Identification of isolation rooms," dated July 2016, stated to "place a notice on the resident's door indicating the type of additional precautions in place (do not indicate any diagnosis or type of infection on sign). An additional sign "Visitors please check with Nursing staff prior to entering" may be used."

Review of the "precaution" sign on the door to resident's room stated the following:
-wear mask and eye protection within 2 metres of resident
-wear gloves for direct care
-wear long-sleeved gown for direct care
-resident must wear a mask if they leave the room
-dedicate equipment to resident or disinfect before use with another

Review of resident's progress notes showed the resident was in isolation and that had symptoms that were consistent with the precautions required.

Review of resident's plan of care showed that the resident was on isolation and to follow the specific policy.

Review of the policy titled "Infection control and Prevention and Control," dated last revised June 2016, did not show directions to directions related to the specific type of infections.

Observation on a specific date a PSW entered the resident's room to serve the resident a drink. The PSW put on a mask and gloves but no gown was donned at that time. On the same date a PSW acknowledged that they did not wear a gown to assist the resident to drink. The PSW shared that when they did care and there was bodily fluids that they needed to wear the gown.

Observation on a specific date showed that a registered staff member went to the medication cart to retrieve a medication, then proceeded into the resident's room to administer a medication via a specific method. The registered staff member was seen wearing gloves and a mask but not a gown. On that same date, it was observed that a PSW entered the room not wearing mask and gown and removed the inhalation therapy and replaced the oxygen.

In an interview the PSW stated that when a resident was isolated the staff were to wear

gowns, gloves and mask during care for the resident. The PSW acknowledged that they did not wear a mask or eye protection when removing the treatment.

In an interview, the registered staff member stated that staff would follow the sign on the resident's door to direct what personal protective equipment (PPE) to wear. The registered staff member stated that when a resident was placed into isolation they would place the proper sign on the door.

In an interview, the Director of Care (DOC) stated that they would expect a mask at all times when you entered a room where a resident was on that specific isolation precaution. The DOC shared that assisting a resident to drink would be considered care, but that administering a medication would not be considered care.

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program. [s. 229. (4)]

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 participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 21st day of February, 2018

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TRACY RICHARDSON (680), DOROTHY GINTHER (568), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2018_678680_0002
Log No. / No de registre :	028142-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 12, 2018
Licensee / Titulaire de permis :	Corporation of the County of Grey 595 9th Avenue East, OWEN SOUND, ON, N4K-3E3
LTC Home / Foyer de SLD :	Lee Manor Home 875 Sixth Street East, OWEN SOUND, ON, N4K-5W5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Renate Cowan

To Corporation of the County of Grey, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, which includes ecchymosis.
(i) Specified resident's and any other resident receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment
(iii) Specified resident and any other resident is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the

resident's plan of care relating to nutrition and hydration are implemented, and
(iv) Specified resident's and any other resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Ontario Regulation 79/10, s. 50 (3) defines altered skin integrity "as the potential or actual disruption of epidermal or dermal tissue."

A) Review of a specified resident's clinical record identified that on a specific date the resident had an un-witnessed fall. The fall note stated that the resident was found beside the bed. There was a suspected injury to an area of the body. A progress note on a specific date documented that the resident presented with altered skin integrity.

Review of a progress note on a specific date for the resident documented that there was a alteration to the resident's skin integrity. The resident denied pain and stated that the altered skin integrity was related to the fall. A progress note, documented that the resident continued to complain of increasing pain with weight bearing during a type of activity of daily living. Assessment of the area mentioned an altered skin integrity that was older. Assessment of the remainder of the body found the specific alteration in skin integrity was present, which the resident stated was from the fall.

During a review of the resident's clinical record there was no evidence that a

skin assessment was conducted in relation to the resident's altered skin integrity as identified in the progress notes.

During an interview with a registered staff member they shared that when a new area of skin concern was identified the registered staff would complete an assessment using the Skin/Wound Care assessment tool on Point Click Care (PCC). The treatment plan for that skin concern would be documented in the Treatment Administration Record (TAR) on PCC. These assessments would be conducted for all types of skin concerns. When asked the registered staff member recalled assessing the specified resident after their fall, the registered staff member said they were off work at the time of the fall. When they returned, the registered staff member stated that the specific resident was having a pain in a specific area. When asked if they recalled seeing any alteration in skin integrity, the registered staff member said they believed the resident had a specific area of altered skin integrity.

In an interview with the ADOC said that there should have been an assessment of the identified altered skin integrity and acknowledged that there were no skin assessments completed.

B) Review of another resident's progress notes identified a post fall note on a specified date, which stated that the resident was found on the floor. The resident had an injury and there was altered skin integrity. A progress note, stated that the resident had a specified alteration in their skin integrity.

During an interview with a registered staff member they shared that when a new skin concern was identified the registered staff would complete an assessment using the Skin/Wound Care assessment tool on Point Click Care (PCC). The treatment plan for that skin concern would be documented in the Treatment Administration Record (TAR) on PCC. These assessments would be conducted for all types of skin concerns including skin tears, lacerations, bruises and wounds.

Upon review of the resident's clinical record there was no evidence that a Skin/Wound Care assessment had been completed for the resident's altered skin integrity which were sustained as a result of the fall.

In an interview with the ADOC, they shared that Skin / Wound Care assessments should be conducted for all areas of altered skin integrity including

skin tears, lacerations and wounds. In terms of bruises, staff may not be completing a Skin/Wound Care assessment but should be documenting a skin observation note in the progress notes on PCC. After reviewing the specific resident's clinical record the ADOC acknowledged that there were no skin assessments for the resident's altered skin integrity. The ADOC agreed that the specific injury was altered skin integrity based on the definition within the Long-Term Homes Regulations, and as such, it should be assessed using a clinically appropriate assessment instrument designed for skin and wound assessment.

C) Review of another resident's progress notes identified a post fall note on a specific date, which stated that the resident had an un-witnessed fall in which they sustained an area of altered skin integrity.

During an interview with the registered staff member they shared that when a new skin concern was identified the registered staff were to complete an assessment using the Skin/Wound Care assessment tool on Point Click Care (PCC). The treatment plan for that skin concern would be documented in the Treatment Administration Record (TAR) on PCC. These assessments would be conducted for all types of skin concerns including skin tears, lacerations, bruises and wounds.

Upon review of the resident's clinical record there was no evidence that an initial Skin/Wound Care assessment was completed for the resident's altered skin integrity.

During an interview the Assistant Director of Care (ADOC) said that it was the home's expectation that areas of altered skin integrity including wounds, lacerations and skin tears would be assessed by registered staff using their Skin/Wound Care assessment on PCC. After reviewing the specific resident's clinical record, the ADOC acknowledged that the home had not completed an initial assessment of both the altered skin integrity following their fall.

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

(568)

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who was a member of the staff of the home.

Review of a specific resident's progress notes identified that the resident fell and sustained a change to their skin integrity. A progress note, stated that the resident had an area of altered skin integrity.

During an interview with the Registered Dietitian (RD) they said that it was the home's practice to refer residents who exhibited a new skin concern to the RD for an assessment. This would include abrasions, skin tears, lacerations, and wounds. When asked if a referral would be made to the RD for a specific type of skin change, the RD said that this was not the home's current practice unless there was a specific concern.

Upon review of the residents' clinical record there was no evidence that a RD had assessed the resident in relation to the altered skin integrity.

In an interview the ADOC said that it was not the home's practice to send a referral to the RD for that specific type of altered skin integrity , and acknowledged that there was no assessment by the RD for the resident in relation to those alterations.

The licensee failed to ensure that the specified resident was assessed by a registered dietitian who was a member of the staff of the home in relation to their altered skin integrity. [s. 50. (2) (b) (iii)] (568)

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Review of a specific resident's clinical record identified that the resident had an un-witnessed fall. There was a suspected injury as the resident reported pain, but there was no change to the resident's skin integrity. A progress note on a

date documented that the resident presented with an alteration to their skin integrity. A progress note documented the altered skin integrity was noted on the resident. The resident denied pain and stated that the alteration of their skin integrity was related to the previous fall. A progress note documented that the resident continued to complain of increasing pain. Assessment of the resident's identified injury noted the resident's altered skin integrity. Assessment of the remainder of the resident's body found alterations to the resident's skin integrity which the resident stated was from the fall.

During a review of the resident's clinical record there was no evidence of a weekly skin assessment in relation to the altered skin integrity as identified in the progress notes.

In an interview with a registered staff member they shared that when a new skin concern was identified the registered staff would complete an assessment using the Skin/Wound Care assessment tool on Point Click Care (PCC). Weekly thereafter the registered staff would reassess the skin concern using the Skin/Wound Care assessment tool. These assessments should be conducted for all types of skin concerns including skin tears, lacerations, bruises and wounds.

In an interview with the ADOC, they said that it was the home's expectation that staff reassess all types of skin concerns, including the specific change in skin integrity on a weekly basis until they resolved. They may not document on the Skin/Wound Care assessment form, but at a minimum there should be a structured skin observation note in PCC under the progress notes.

After reviewing the resident's clinical record, the ADOC acknowledged that there were no weekly skin assessments completed in relation to the resident's altered skin integrity.

B) Review of another resident's progress notes identified a post fall note on a specific date, which stated that the resident had fallen and sustained an injury with an alteration in skin integrity.

Upon review of the resident's clinical record there was no evidence that weekly Skin/Wound Care assessments had been completed for the resident's altered skin integrity which were sustained as a result of the fall.

During an interview with a registered staff member they shared that when a new area of skin concern was identified the registered staff would complete an assessment using the Skin / Wound Care assessment tool on Point Click Care (PCC). They would then complete weekly Skin / Wound Care assessments of the identified skin concerns until they were resolved. These assessments should be conducted for all types of skin concerns including skin tears, lacerations, bruises and wounds.

In an interview with the ADOC said that it was the home's expectation that staff reassess all types of skin concerns, including the specific change in skin integrity on a weekly basis until they resolved. They may not document on the Skin/Wound Care assessment form, but at a minimum there should be a structured skin observation note in PCC under the progress notes.

After reviewing the resident's clinical record, the ADOC acknowledged that there were no weekly skin assessments completed in relation to the resident's altered skin integrity.

C) Review of another resident's progress notes identified a post fall note on a specific date, which stated that the resident had an un-witnessed fall. The post fall note stated that as a result of the fall the resident sustained an injury and had altered skin integrity.

During an interview with a registered staff member they shared that when a new skin concern was identified the registered staff were to complete an assessment using the Skin / Wound Care assessment tool on Point Click Care (PCC). The treatment plan for that skin concern would be documented in the Treatment Administration Record (TAR) on PCC. These assessments should be conducted for all types of skin concerns including skin tears, lacerations, bruises and wounds.

Upon review of the resident's clinical record there was no evidence that the resident's altered skin integrity were reassessed weekly.

During an interview with the Assistant Director of Care (ADOC), they said that it was the home's expectation that areas of altered skin integrity would be reassessed at least weekly by registered staff using their Skin / Wound Care assessment on PCC. The ADOC acknowledged that the home had not reassessed the resident's altered skin integrity.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 history of one or more related non-compliance with this section of the Act that included: voluntary plan of correction issued on October 17, 2016, during a critical incident inspection #2016_448155_0016, voluntary plan of correction issued on January 18, 2018 #2017_678680_0024. [s. 50. (2) (b) (iv)] (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 19, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall ensure that when the specified resident's and any other resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Grounds / Motifs :

1. 1. The licensee has 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.

Review of a specified resident's clinical record identified a fall note on a specific date, which stated that the resident had been found on the floor. There was a suspected injury as the resident claimed pain in the same area. Progress notes from a specific date and time to another date and time which was 23 days later, showed that the resident had been experiencing pain and was receiving analgesic for that specified pain related to injury incurred at the time of the fall.

The electronic Medication Administration Record (eMAR) identified that the resident had an order for a specific analgesic at a specific time. It was documented that the resident received this medication. The eMAR also documented an order for different analgesic to be given every four hours as needed (PRN). It was documented that the resident received that analgesic on 10 occasions during a specific time frame. There was no evidence that a pain assessment was conducted for the resident during the time they fell and when the doctor assessed them.

During an interview with a Personal Support Worker (PSW) and registered staff member they said that prior to the resident's fall, the resident was very independent. After the fall, the resident had reported increasing pain which limited their ability to walk. Instead they required assistance with a device to go the dining room. The resident required more assistance with their activities of daily living. The registered staff member shared that prior to the fall the resident rarely complained of pain and never asked for extra medication.

The home's policy VII-G-30.10 titled "Pain & symptom Management" approved and revised December 2015, stated under the "Procedure" that registered staff would conduct and document a pain assessment electronically on initiation of a pain medication or as needed analgesic, when there was a change in condition with pain onset, when a resident reported pain or symptoms of greater than four on a numerical ten point scale for 24 to 48 hours.

In an interview the Assistant Director of Care (ADOC) said that given the resident's fall, the onset of a new pain, and the administration of as needed (PRN) medication for pain, it would be the home's expectation that a pain assessment be conducted using their Pain Assessment V4 tool on Point Click Care (PCC). the ADOC acknowledged that the resident did not have a pain assessment when initial interventions did not relieve their pain. [s. 52. (2)]

2. Review of another resident's clinical record identified that the resident had three un-witnessed falls in an identified month, over a three day period. As a result of one of the falls the resident sustained an injury and had altered skin integrity.

During an interview with a PSW they said that the resident reported pain on almost a daily basis to specific areas of their body. The resident would usually go to the nurse when they were uncomfortable and needed medication. The PSW said that the resident did not always tell them they had pain, but it was evident in other ways such as withdrawal from activities and the need for more assistance with their activities of daily living.

In an interview with the specific resident, they shared that they experienced pain on almost a daily basis to specified areas of their body. The resident said that their pain had worsened and they were having to take more medication to control the symptoms. They were unsure as to why the pain worsened but said they had a number of falls which may have contributed to it. Their physician had

just recently changed their medication to help with better pain control.

The electronic Medication Administration Record (eMAR) for a certain month documented that the resident received their regularly scheduled analgesic three times a day as ordered for pain control. In addition, the resident received an as needed (PRN) dose of analgesic a specific amount of times during the specified month. It was noted that when the PRN medication was given the resident's pain level was assessed using a numerical pain scale which ranged between five and eight out of ten. There was no further assessment of the pain in terms of its location, frequency and quality. In two specific months, the eMAR documented that the resident received a PRN dose of analagesic a specified number of times in each of the months. Pain levels were documented using the numerical pain scale and ranged between five and nine out of ten.

In an interview a registered staff member shared that the resident had chronic pain to specific areas of their body. The resident had a number of falls in the last quarter and their pain seemed to have increased. During the three month medication review, it was noted that the resident was being given more PRN analgesics and the physician had made some medication changes to provide for better pain control. On a specific date, the physician ordered an increase of a specified analgesic.

During a review of the residents clinical record there was no evidence that the resident's pain had been assessed beyond the numerical pain scales documented at the time that the PRN medication was given.

The home's policy VII-G-30.10 titled "Pain & Symptom Management" approved and revised December 2015, stated under the "Procedure" that registered staff would conduct and document a pain assessment electronically on initiation of a pain medication or PRN analgesic, when there were behaviours exhibited by a resident that may be an indicator for the onset of pain, when a resident reported pain or symptoms of greater than 4/10 for 24-48 hours, when they received pain medication for greater than 72 hours.

In an interview the ADOC said they agreed that the resident should have had a full pain assessment conducted using the Pain Assessment V4 tool on PCC given that the resident's pain had not being relieved by initial interventions and PRN analgesics were being given at an increased frequency to manage symptoms. [s. 52. (2)]

3. In a review of another resident's plan of care it was noted that the resident experienced pain to specific areas of their body. On a specified date a Physiotherapy Assessment Note stated that the resident was still complaining of a specific type of pain that radiated. At that time the pain was rated four out of a possible ten on the numerical pain scale. The assessment stated that there had been no improvement in pain from the last quarter.

In an interview with the resident they shared that they experienced pain to specific areas of their body, some days worse than others. The resident stated that they took medication to help control the pain but some days it was not enough. On those occasions they would ask the nurse for extra medication. The resident said that more recently the pain had been worse but they didn't know why.

The electronic Medication Administration Record (eMAR) documented the medication orders and administration for the period of one specific month. The eMAR documented the date of the order and the administration of the medication that had been given.

During an interview the PSW said that lately the resident had been exhibiting more signs of pain to a specific area of their body. Sometimes the resident would tell them about the pain and other times it was evident by the way the resident was performing an activity of daily living. A registered staff member told the inspector that the resident had chronic pain to certain areas of their body. The resident was not someone who liked to ask for pills but they could tell when the pain worsened because they became quiet and withdrawn. They would also have a lot of difficulty performing a specific activity of daily living. The registered staff member said that the physician had recently increased resident's pain medication because it was found they were taking more of the PRN medications.

Physician notes and orders on a specific date, stated that the resident had pain. New orders for increase to a specific medication in the morning, at noon and before bed. A specific analgesic was increased to a specified amount daily.

During a review of the resident's clinical record there was no evidence that the resident had a pain assessment completed in the last six months.

The home's policy VII-G-30.10 titled "Pain & Symptom Management" approved and revised December 2015, stated under the "Procedure" that registered staff would conduct and document a pain assessment electronically on initiation of a pain medication or PRN analgesic, when there were behaviours exhibited by a resident that may be an indicator for the onset of pain, when a resident reported pain or symptoms of greater than four out of ten for 24-48 hours, when they received pain medication for greater than 72 hours.

In an interview the ADOC said they agreed that the resident should have had a full pain assessment conducted using the Pain Assessment V4 tool on PCC given that the resident's pain was not being relieved by initial interventions and PRN analgesics were being given at an increased frequency to manage symptoms.

The licensee has 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.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 history of one or more related non-compliance with this section of the Act that included: voluntary plan of correction issued on January 18, 2018 #2017_678680_0024. [s. 52. (2)] (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 19, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Tracy Richardson

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