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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2018	2018_704682_0005	019754-17, 021665-17, 023599-17, 025751-17, 026144-17	Critical Incident System

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

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

R. H. Lawson Eventide Home
5050 Jepson Street NIAGARA FALLS ON L2E 1K5

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

AILEEN GRABA (682), GILLIAN HUNTER (130)

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): February 13, 14, 15, 16, 20, 2018.

This Critical Incident System inspection was done concurrently with the following inquiries: 023792-17 related to falls prevention, 026517-17 related to missing resident, 000017-18 related to sufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Assessment Instrument (RAI) coordinator, registered staff, personal support workers (PSW) and residents.

During the course of this inspection, the inspector observed the provision of the care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) According to resident #004's clinical record, the resident had ongoing complaints of pain, for which they required analgesic medication. The home's policy titled: Pain Management Policy, revised May 15, 2017, directed staff to complete the "Complete Pain Assessment", upon readmission, quarterly and when pain was indicated. The DOC confirmed that a Complete Pain Assessment had not been completed for the resident since the time of their admission and when pain was indicated. Resident #004 was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose. (Inspector #130).

B) A clinical record review on identified dates in 2017, indicated that resident #002 had ongoing complaints of pain, for which they required analgesic medication. The DOC acknowledged in an interview on an identified date in 2018, that the Complete Pain Assessment had not been completed for resident #002 when pain was indicated. Registered staff #200 acknowledged in an interview on an identified date in 2018 that a pain assessment was not done when indicated for resident #002. The DOC acknowledged that resident #002's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose. (Inspector #682) [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

A) On identified dates in 2018, resident #004 was observed to have a prescribed medication stored in their bathroom. A review of the Medication/Treatment Administration (MAR/TAR) records were reviewed and revealed that there was no physician's order authorizing the resident to self administer the medication. The DOC confirmed the resident did not have an order to self administer the prescribed medication and therefore the medication should have been kept in the medication room and administered by registered staff. (Inspector #130). [s. 131. (5)]

Issued on this 6th day of March, 2018

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

Original report signed by the inspector.