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
Mar 26, 2018	2018_580568_0005	008601-17, 009194-17, 015636-17, 015738-17, 018218-17, 022202-17, 026397-17, 029595-17	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Riverside Glen
60 Woodlawn Road East GUELPH ON N1H 8M8

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

DOROTHY GINTHER (568), JANETM EVANS (659), NUZHAT UDDIN (532), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 8, 9, 13, 14, 15, 16, 20, 21, 22, 23, 26, 27, 28, 2018 and March 1, 2018.

The following intakes were completed in this complaint inspection:
IL-50601-LO / log #008601-17 related to falls and continence;
IL-52259-LO / log #018218-17, IL-52983-LO / Log #022202-17, IL54723-LO / log #029595-17, IL-51865-LO / log # 015636-17 related to multiple care concerns;
IL-50731-LO / log #009194-17 related to abuse;
IL-46322-LO / log #015738-17 related to housekeeping, misappropriation of funding, and toileting;
HLTC2966MC-2017-9794 / log #026397-17 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager, Director of Nursing and Care, Assistant Directors of Nursing and Care, Neighbourhood Coordinators, Director of Environmental Services, Assistant Director of Food Services, Registered Nurses, Registered Practical Nurses, Personal Care Aides, Housekeepers, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Snack Observation

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident requiring end-of-life care received care that met their needs.

This inspection was completed in response to a complaint which alleged concerns related to ineffective pain management for the identified resident at end-of-life.

Review of clinical records identified that the resident was deemed palliative on a specified date.

The home's policy for Palliative/End of Life Care , Tab 04-50 documented under that procedures:

"3. Team members will monitor the resident's pain levels, and pain control will be accomplished through appropriate pharmacological and non-pharmacological interventions. This may involve recording vital signs, but is not intended to be intrusive. 4. The resident may be repositioned every 1-2 hours and care provided to reduce skin breakdown and relieve pressure areas. Mouth care may be offered every 2-3 hours to remove oral secretions and maintain moisture to lips. Sips of fluid may be offered if the resident is able to swallow. If discomfort is observed when care is provided, the RN/RPN will be notified and the care team will ensure pain relieving interventions are administered as per the resident's MAR and/or plan of care."

The plan of care for the identified resident included that the resident's response to pain and medications or therapeutics aimed at abolishing or relieving pain should be documented and that staff were to monitor for changes in general condition that may prompt the need for a change in pain relief methods. In addition to this, staff were to notify the physician if interventions were unsuccessful or if the current complaint of pain was a significant change from the resident's past experience.

A review of the clinical record showed a new order for a specified pain medication to be

administered on a regular basis as needed (PRN). In addition, two other medications had been prescribed on a PRN basis with an indication for use as "palliative care".

During a review of the clinical record on a specified date, it was documented in the electronic administration record (EMAR) that a pain medication was administered on a few identified days and was ineffective.

There was no documentation related to alternative medications being administered, alternative comfort measures implemented, or that the physician had been notified of the identified resident's ongoing discomfort.

In interviews with three registered staff, they stated that when a PRN pain medication was administered staff were to do a "pain ad assessment", which included follow up to see if the pain medication administration was effective or not. If the medication was not effective, they were to give another dose or notify the physician. The registered staff said they could see if other medications were available for administration or try to implement alternative non pharmacological interventions.

In an interview with the Director of Nursing Care (DNC) and Assistant Director of Nursing Care (ADNC) they stated that if the administration of a pain medication was not effective, staff should look to see if there were any PRN medications or other analgesics that could be administered; explore non pharmacological interventions that could be implemented, complete a pain assessment, and notify the physician if the resident's pain was not controlled. The DNC and ADNC reviewed the EMAR and associated documentation for the identified resident and acknowledged that this had not been done for the resident when the administered medication had not been effective for pain relief and the resident continued to exhibit signs of pain or discomfort.

The licensee has failed to ensure that a resident requiring end-of-life care received care that met their needs. [s. 42.]

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 resident requiring end-of-life care receives care that meets their needs, to be implemented voluntarily.

Issued on this 16th day of April, 2018

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

Original report signed by the inspector.