Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 8, 2019	2019_730593_0018	027214-18, 009487-19	Complaint

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Springdale Country Manor
2698 Clifford Line, R.R. #5 PETERBOROUGH ON K9J 6X6

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

GILLIAN CHAMBERLIN (593), JOELLE TAILLEFER (211)

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): June 10 - 14, 2019.

Two complaint intakes were inspected during the inspection, including log #027214 -18 related to staffing and log #009487-19 related to plan of care. Log #024987-18 (CIS) was inspected as a complaint and related to responsive behaviours and alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Nursing Administration Services Manager, Food Service Manager, registered physiotherapist, registered nursing staff, personal support workers, dietary staff, residents and family members.

The inspector(s) observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, staff schedules and licensee policies.

The following Inspection Protocols were used during this inspection:
Pain
Personal Support Services
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care for resident #006 was provided to the resident as specified in the plan of care.

A critical incident report (CIS 2413-000020-18) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), reporting the alleged abuse of a resident by resident #006. It was reported in the CIS that RN #101 was exiting the medication room when they saw resident #006 talking to a resident who was leaning over and they had their hands on a their body.

A complaint was received via the Action Line regarding concerns with responsive behaviours of residents and allegations of resident to resident abuse.

A review of resident #006's documented plan of care, found the following:

• Staff to protect other residents, never leave resident #006 alone with other confused residents and limit their access to vulnerable residents i.e- position them in low traffic areas, if in TV room make sure people have room to enter/exit and that they don't sit near the door.

• Triggers: any resident giving them attention, opportunity to be in close contact with staff/ residents.

A review of resident #006's progress notes since the critical incident, found the following:

• Staff witnessed resident #006 place their hand on another resident, staff intervened.
• Resident #006 has been witnessed by staff, grabbing three different residents by the hands this evening. Resident #006 was informed that this was inappropriate and segregated from other residents. 1:1 given by activation staff this evening.
• Resident #006 was found putting their hand on another residents arm up front, while they were sleeping, staff intervened and moved resident #006 away from the area.

Observations by Inspector #593, found the following:

June 10, 2019, 1535 hours- resident #006 is observed to ambulate to the front lounge area, there are six residents seated in this front area. Resident #006 is seen to reach out to resident #011 who moved their hand away before they touched them. They then reached for their hand, resident #011 says "get the (explicit) away", they move their hand and then they reached and grabbed their hand again, the resident held their hand for a short while and then pushed them away. Resident #006 was then observed to try to touch resident #011's leg, the DOC then intervened and moved resident #006 to the

other side of the lounge area.

During an interview with Inspector #593, June 13, 2019, PSW #111 indicated that resident #006 has behaviours that they direct toward both staff and residents. Resident #006 is not supposed to be around specific residents, if a specific resident sits near them, we are to move one of them. Mostly they sit in the front lounge, so that they can be supervised by staff.

During an interview with Inspector #593, June 13, 2019, RN #101 indicated that staff have to be very careful to keep resident #006 away from specific residents, they hold their hands, this is how it starts. RN #101 added that we don't have the resident sitting anywhere near specific residents. Not even seated next to specific residents, whether it's an activity or watching TV, they should be back out of the way. It does not take much for them to move, it happens so fast so we cannot have the resident close to specific residents.

During an interview with Inspector #593, June 14, 2019, the DOC indicated that the expectation is that staff should be watching resident #006 and they are to be redirected, if they approach specific residents.

Resident #006 has a history of behaviors towards other residents in the home. As a result, the written plan of care had interventions to manage this. Staff interviewed were aware of such interventions however on multiple occasions, as described above, the plan of care was not followed resulting in resident #006 with the opportunity to touch other residents in the home. As such, the licensee has failed to ensure that the plan of care for resident #006 was provided to the resident as per the plan, to protect other residents in the home. (Log #027214-18, 009612-18, 030637-18) [s. 6. (7)]

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 ensuring that the care set out in the plan of care for resident #006 was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Where the Act or this regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

The Ministry of Health and Long Term Care Action Line received a call from resident #002's family member stating that on the previous day, a friend who visited resident #002 indicated that the resident was complaining of abdominal and back pain.

Review of the home's policy #OTP-PM-6.3 titled Pain Assessment dated May 2017 stated that a Pain Assessment shall be completed:
-At the time of admission for a period of seven days for each shift,
-On paper or in the electronic medication record.

Review of resident #002's health care records indicated that the resident was admitted in the home and discharged nine days later.

Review of resident #002's electronic health care records under section Pain Assessment indicated that the Edmonton Symptom Assessment System (ESAS) was completed on Day 1 and then Abbey Pain Scale assessments were completed on the following dates:
- Day 4 at 0200 hours, 0830 hours, and 1400 hours.
- Day 5 at 0730 hour, 1400 hours and 1730 hours. Another assessment was completed on that date but without the time.
- Day 6 at 0730 hours and 1730 hours.
- Day 7 at 0730 hours and 1730 hours.
- Day 8 at 0800 hours. Another assessment was completed on that date but without the time.

In an interview with the DOC on June 13, 2019, stated that the Pain Assessment Policy indicated that the pain evaluation tool shall be completed for a period of seven days for each shift from the date of a resident's admission. Two pain assessment tools were used to assess the resident's level of pain. A pain assessment titled "Pain Assessment in Advanced Dementia" (PAINAD) was completed on day 1 and then the pain assessment tool titled "The Abbey Assessment Scale" was initiated on day 4. However, the Abbey Assessment Scales were not always used every shift. The DOC confirmed that the pain evaluation tools to assess resident #002's level of pain were not consistently used every shift as indicated in their Pain Assessment policy. (Log #009487-19) [s. 8. (1) (a),s. 8. (1) (b)]

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 ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #002's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The Ministry of Health and Long Term Care Action Line received a call from resident #002's family member stating that on the previous day, a friend visited resident #002 and the resident was complaining of abdominal and back pain. The friend informed resident #002's family member that the resident received Tylenol at 0800 hours and no other pain medication was given between the hours of 0800 hours to 1730 hours.

The resident's Medication Administration Record (MAR) indicated that resident #002 received Tylenol 325 mg two tablets by mouth at 0855 hours and 1630 hours.

Resident #002's Abbey Pain Scale completed on this same day indicated that Tylenol was given at 0800 hours as a pain relief and the pain level score was "No pain". A

second electronic Abbey Pain Scale assessment was completed indicating that Tylenol 650 mg by mouth was given for pain relief as a PRN. The time given was not documented. The pain level score was identified has mild.

The resident's progress notes on this same day indicated that the resident received Tylenol 325 mg two tablets at 1630 hours.

Review of resident #002's health care record under the section Pain Assessment from Day 1 to Day 9 indicated the following:

On Day 1, the Edmonton Symptom Assessment System (ESAS) was completed indicating that the resident's pain locations were joint pain (other than hip), back pain and bone pain. The frequency of the pain was less than daily. The intensity was moderated and the onset was chronic. The quality of pain was ache and caused during the activity of daily living (ADL) function. The resident was not vocalizing the pain. However, the resident's pain was demonstrated with facial expression such as fearful and by guarding the body position. The current pain control was satisfied with when necessary (PRN) analgesic.

On Day 4, the Abbey Pain Scale was initiated. The Abbey Pain Scale Assessments were completed as followed:
-Tylenol 650 mg by mouth was given on Day 4 at 0200 hours, 0830 hours, and 1400 hours. The pain level was described has "No pain at 0200 hours, moderate at 0830 hours and mild at 1400 hour.
-Tylenol 650 mg by mouth was given on Day 5 at 0730 hour, 1400 hours, and as needed. The pain level was described has moderate at 0730 hours. The pain level at 1440 hours and under the PRN assessment was described has "No pain". The resident was offered Tylenol on Day 5 at 1730 hours and assessment indicated that the resident spit it out. The pain level was described was moderate.
-Tylenol 650 mg by mouth was given on Day 6 at 0730 hours. The Tylenol was offered on Day 6 at 1730, but the resident spit it out. Both pain level were assessments has "No pain".
-Tylenol 650 mg by mouth was given on Day 7 at 0730 hours and the pain level was "No pain". Tylenol 650 mg by mouth was offered at 1730 and the assessment indicated that the resident spit it out. At that time, the pain's level was "No pain". On that day, two other Abbey Pain Scale were documented as PRN. One of the Abbey Pain Scale indicated that the pain level was assessed has "No pain" and the second pain assessment was identified has mild.

-Tylenol was given on Day 8 at 0800 hours and indicated that the level of pain was "No pain". On the same day, Tylenol 650 mg by mouth was given as a PRN and the pain's level was mild.

Review of the resident's progress notes by inspector #211, indicated that occasionally the registered staff did document the resident's pain as followed:
-RN #115 wrote on Day 2 at 1422 hours, that the resident was administered Tylenol plain for sore back at 1145 hours.
-RN #113 wrote on Day 3 at 0745 hours that the resident did not voice any complaints.
-RPN #114 documented on Day 3 at 1431 hours, that the resident was always expressing sore back and Tylenol was given at 0800 hours and 1200 hours with fair effect.
-RN #109 wrote on Day 3 at 1957 hours that resident was complaining of back pain and was started on the Abbey Pain Scale.
-RN # 117 wrote on Day 4 at 0732 hours that the resident received Tylenol at 0200 hours for lower back pain with good effect.
-RN #109 wrote on Day 4 at 1025 hours that the resident complained of back pain stating "My back". Tylenol 650 mg was given at 0830 hours with effect. The resident's pain was documented in the physician book.
-RN #109 wrote on Day 4 at 1359 hours that the resident continues to complain of lower back pain. Tylenol was given again at 1400 hours.
-RN # 117 wrote on Day 5 at 0731 hours that the resident had a good night sleep and did not require analgesic. To continue to monitor resident's lower back pain.
-RN # 117 wrote on Day 6 at 0731 that the resident received Tylenol at 2325 hours for back pain with good effect.
-RN #109 wrote on Day 7 at 1703 hours that they documented in the physician's message book that the resident was complaining of lumbar back pain and needing analgesic routine.

In conclusion, the registered nursing staff did not always document in resident #002's progress notes if the analgesic administered was effective.

In an interview with the DOC on June 13, 2019, stated that the electronic Abbey Pain Scale assessment conveyed confusion as the time of the analgesic given was not always documented. The DOC stated that the resident's Medication Administration Record (MAR) indicated the time the analgesic was given but did not indicate if the intervention was effective. The Abbey Pain Scale assessment doesn't indicate if the resident's pain level was effective after receiving the analgesic. (Log #009487-19) [s. 52. (2)]

Issued on this 10th day of July, 2019

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

Original report signed by the inspector.