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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 6, 2014	2014_220111_0005	O-000127-14	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

LYNDA BROWN (111), CAROLINE TOMPKINS (166), MARIA FRANCIS-ALLEN (552), MATTHEW STICCA (553)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 19, 20, 21, 24, 25 & 26, 2014

The following complaint inspections were completed concurrently during this inspection (log #001054, 000101, 001118) and the following critical incident was completed concurrently during this RQI inspection (log # 0001102).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Environmental Services Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW),Physiotherapist (PT), Physiotherapy Assistant (PTA), Family Council President, Resident Council President, Food Services Manager, RAI-Coordinator, Housekeeping staff, Dietary Aides, Residents and Families.

During the course of the inspection, the inspector(s) toured the home, observed a dining service, reviewed resident health records, reviewed the home's investigation reports, and reviewed the home's policies (zero tolerance of abuse and neglect, falls, skin and wound, restraints, PASD, pain, infection control and prevention, medication administration and transcription of medications).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee was issued non-compliance related to LTCHA, 2007, s.6(1)(c) on October 28, 2013 during inspection # 2013_195166_0040.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to the use of restraints and PASD's:

Observation of Resident #2494 indicated a PASD was applied to the resident;
-Review of the progress notes for Resident #2494 indicated the resident was to have the PASD in use at all times to help reduce the risk of a fall.
-Interview of Staff #108, indicated the resident had been using the PASD for safety while in the wheelchair and bed for a period of greater than 2 months.
-Review of the plan of care for Resident #2494 had no indication of a PASD in place. (553)

There was no clear direction on the plan of care regarding a restraint that was in use and no interventions to manage the risks associated with restraints.

Observation of Resident #2526 indicated the resident had a physical restraint in place;
-Interviews of Staff #102, #104, #105, #106 and #107 all had conflicting responses related to the use of the restraint.
-Review of the care plan related to Resident #2526 does not indicate that the resident used a restraint,
-The "Resident's Requiring Restraints" list did not include Resident # 2526 as using a restraint.(552)

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

Review of the progress notes for Resident # 2524 indicated:
-the resident developed two pressure areas and two days after developing the pressure areas, the resident developed intense pain as a result.The resident continued to complain of pain for a period of 6 days.
-Review of the Medication Administration Record (MAR)during the same period of time indicated the resident had routine narcotic analgesic ordered and narcotic analgesic ordered for breakthrough pain. During the period the resident demonstrated pain related to the pressure area, the resident only received breakthrough analgesic on two instances.
-Review of the plan of care for Resident #2524 related to comfort indicated the resident had both constant and occasional moderate pain related to immobility.The interventions included administering medication as ordered and assess effectiveness;assess the residents pain for a set number of days to establish any patterns.
-There was no clear direction related to the "location of pain", whether the resident had "occasional" or "constant pain". There was also no clear direction how staff would "assess effectiveness" or what "a set number of days" referred to.(111)

Review of the clinical health records for Resident # 2514 indicated:
-Progress notes indicated the resident sustained a fall resulting in the resident complaining of pain and was resistive to range of motion (ROM)for a period of 5 days.
-The resident was not taken to hospital for a period of 5 days post fall and was diagnosed with an injury.
-Review of the resident's "Pain Assessment and Evaluation Tool" (completed the day after the fall) indicated the resident had "no pain". There was no documented evidence

of any further pain assessment tools completed.
-Review of the MAR for the period before and after the fall indicated the resident received routine analgesic four times daily. There were no other medications available for breakthrough pain and no indication the resident received any other analgesic when the resident continued to complain of pain.
-Review of the care plan post fall for Resident # 2514 related to comfort indicated a potential for discomfort related to a previous injury.Interventions included: mild pain, analgesic four times daily and staff to monitor for pain and discomfort during care and report any changes to registered staff.
-There was no clear direction related to the location of the resident's pain or appropriate interventions to manage the resident's increased pain related to the new diagnosis of an injury.(111)

3. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to skin and wound care:

Review of the health care record for Resident #2524 indicated:
-The progress notes indicated the resident developed skin breakdown and another skin care issue to another area. 6 days later,the skin breakdown deteriorated in condition.13 days later, developed a third skin care issue.
-Review of RAI-MDS for Resident #2524 indicated under Pressure ulcers indicated: the resident is high risk for skin breakdown related to bed mobility problem and bowel/bladder incontinence, uses pressure relief devices, and "has no skin breakdown".
-Review of the plan of care for Resident #2524 indicated altered skin integrity (pressure ulcers).Interventions included offering nutritional intervention as ordered to promote wound healing and on supplements with added protein but meal intake is poor.
-There was no clear direction related to all areas of altered skin integrity and appropriate interventions to manage the risks associated with altered skin integrity. (111)

4. The licensee failed to ensure that the plan of care set out clear directions to staff and other who provide direct care to the resident related to oral hygiene:

Review of the health care record for Resident #2494 indicated:
-Review of PSW's flow sheets related to oral care for a 4 month period indicated their were 52 documented incidents when the resident did not receive oral care. 26 out of

the 52 times was due to "R".
-Interview of Staff #109 and #110 indicated "when there is an "R" on the PSW flow sheet it means the resident would have refused oral care and that oral care would not have been completed". Staff #110 indicated Resident #2494 "has been known to become aggressive with staff when oral care is attempted".
-Review of the plan of care during that same time period related to oral care indicated interventions as daily cleaning of teeth or dentures, daily mouth care by client or staff, 1 staff to provide total assist with mouth care due to medical conditions, staff to monitor oral cavity for any lesions, open areas, etc.(and report any concerns to registered staff),staff to place tooth paste on toothbrush and hand to the resident and then request the resident to brush their own teeth,and if the resident refuses to complete, staff to perform care for them.

There was no clear direction whether the resident had teeth or dentures (or both). It was unclear whether staff was to perform the activity or the resident, and the direction given for when the resident refuses, contradicted the original direction.(553)

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to risk of falls.

Review of the health care record for Resident #2514 indicated:
-the Progress notes indicated the resident was found on the floor in the doorway of another resident's room on a specified date and was subsequently diagnosed with an injury. Approximately 2 1/2 months later, the resident sustained a second fall.
-The post fall assessment completed after the first fall indicated the action plan was to complete head injury and every 15 minute checks. The post fall assessment after the second fall indicated the action plan was to complete every 15 minute checks for one month and complete head injury.
-The care plan indicated the resident was a high risk for falls related to unsteady gait.
-There was no indication when the resident was reassessed, the plan of care was revised to indicate the resident had a history of falls (resulting in injury) and the resident was to be on every 15 minute checks x1 month post falls.

Review of the health care record for Resident # 2526 indicated:
-Progress notes indicated the resident sustained two falls approximately one month apart.
-RAI/MDS post falls indicated under J4 (accidents) "no falls/fractures in past 30 days or 31 to 180 days".

-the resident list for "high risk for falls" did not include Resident #2526.
-the nursing quarterly summary indicated the resident was at high risk for falls but did not provide any interventions to address the resident's risk for falls.
-the care plan identified the resident as high risk for falls but no interventions were documented.

The licensee was issued non-compliance to LTCHA, 2007, s. 6(10)(b) on October 28, 2013 during inspection# 2013_195166_0041.

Additional Required Actions:

CO # - 001, 002 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. 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. Under O.Reg. 79/10, s. 30(1) Every licensee of a long-term care home shall ensure that the following is complied with in respect with each of the organized programs required under sections 8-16 of the Act and each of the interdisciplinary programs required under section 48 of this regulation.

O.Reg. 79/10, s.48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:2.A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers and provide effective skin and wound care interventions.

Review of the homes policy "Pressure Ulcer and Wound Management" (HLHS-

SW-3.6) (revised January 2012) indicated:
For Wounds stage 1-4 and stage X (un-stageable)
-complete Braden Scale assessment tool.
-assess and monitor care approaches to relieve/reduce pain.
-refer to occupational therapist and/or physiotherapist for positioning and seating assistance.
-reassess the ulcer weekly and document.
-treat ulcer as per Healthy Living, Health Skin Protocol and document on the attached form "NCP and Treatment Sheet" (which provides the assessment of wounds, treatment to be used and frequency of dressing changes).
-the "NCP and Treatment Sheet" indicates for an "un-stageable wound", the frequency of dressing changes to be every 3-5 days and use of "algisite M" for wounds exhibiting moderate to heavy drainage.

Review of the health records for Resident #2524 indicated:
-the resident developed a wound which deteriorated and developed two other reddened areas. The resident had verbalized ongoing pain related to the pressure ulcer.
-the Treatment Administration Record (TAR) indicated the resident was to have dressing changes completed "every 2 days" and use of "acticoat".
-the "Assessment Sheet for Wounds" for the wound indicated "large exudate".

Interview of RPN #102 indicated that all treatments for wounds require a physician's order and confirmed there was no physician's order in place for Resident #2524 two treatments.

There was no documented evidence of:
-a current Braden Scale Tool,
-no indication the resident was assessed for pain using a clinically appropriate assessment tool,
-no evidence of a referral to occupational therapy/physiotherapy for a period of 12 days.
-there was no assessment sheet available for the two reddened areas.
-there was no indication of the use of the "NCP and Treatment Sheet"
-there was no indication of a physician's order for the current treatment and the current treatment did not match the required treatment as per the NCP and Treatment Sheet.

2. Under O.Reg. 79/10, s.90(1) As part of the organized program of maintenance services under clause 15(1)(c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventative and remedial maintenance.

During an initial tour of the home (by inspector #166 & #552) and subsequent tour (by inspector #111), it was noted that 5 ceiling tiles had large water-stains on Wind-over Trail unit (outside of room 9 & 10), and 3 large water-stained ceiling tiles near Memory Lane nursing station.

Inspector #553 observed in the bathroom of room 25, the ceiling was cracked with a diameter of approximately 8 inches that had been previously repaired with drywall compound but remained incomplete.

Interview of the Environmental Services Manager(ESM) indicated there is two preventative maintenance checklists to be completed by the maintenance person. The ESM indicated the "admission/discharge/transfer Cleaning and Maintenance Checklist" is only completed during a resident room change/admission/or discharge and is specific to the residents rooms requiring maintenance. The ESM indicated the "Monthly Preventative Checklist" is related to the maintenance of the remainder of the home. The ESM also indicated in addition to the preventative checklists, there is an informal "honey do list" which is prepared by the ESM and provided to the maintenance person to complete. The ESM indicated the stained ceiling tiles in the hallways "have been like that for approximately one year".

Review of the monthly preventative maintenance checklist for December 2013, January 2014 and February 2014 indicated under item #31:"ceilings and ceiling tiles are in a good state of repair and free of damage" did not indicate any deficiencies. There was also no indication of resident room #25's bathroom ceiling in disrepair.

Review of the untitled "honey do list" indicated ceiling tiles and resident room #25 bathroom ceiling was identified as requiring repair but not completed.

Review of the home policy on "Preventative Maintenance Program" (revised March 2008) indicated:
-preventative maintenance shall be carried out throughout each month in accordance with the checklist

-as each item is inspected/serviced, it shall be dated and initialed on the checklist.
-deficiencies and corrective action shall be documented.

There was no indication the deficiencies were identified on the preventative maintenance checklists.

3. Under O.Reg. 79/10, s.114(2)The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration,and destruction and disposal of all drugs used in the home.

Review of the home's policy "Monthly MAR/TAR Checking & Updating" (8-2)indicated:
-check each order on the new MAR/TAR sheet with the current MAR/TAR sheet.
-sign and date in the box indicating first check.
-ensure that the TARS are complete with a description and location of affected area and the date on which the treatment was initiated.
-check the new MAR/TAR sheets before the end of the month against the current physicians orders back to the date which the previous months MARS/TARS were checked, sign and date in the box indicating second check.

Review of the Treatment Administration Records (TARS) for resident #2524 indicated:
-the 2 current TARS available in the treatment binder that were reviewed were not dated to indicate which month they were for, did not indicate any signatures at the bottom of the TAR by registered staff to indicate the TARS were checked against previous month TAR or against a physicians order, and the new orders transcribed were not dated or signed.
-there was no documented evidence of a physician order for the treatment.
review of TARS for 4 other resident's indicated no dates were indicated on the current and previous month TARS. The treatments were not dated or signed and the TARS had no first or second checks at the bottom of the TARS.

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 home's policies related pressure ulcer and wound management, preventative maintenance, and transcriptions of medications and treatments, are complied with, to be implemented voluntarily.

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. Related to log#O-000101-14:

The licensee failed to ensure that the policy that promotes zero tolerance of abuse was complied with.

The licensee's policy "Zero Tolerance of Abuse and Neglect of Residents"(AM-6.9) states:
-"Every incidence of alleged, suspected or witnessed neglect or abuse shall be immediately reported to the Omni Home Office..."
-"Notify the police of any alleged, suspected or witnessed incident of abuse ...as required"
-"Report each suspected or confirmed incident of abuse or neglect to the Ministry of Health and Long Term Care."

Review of the homes investigation for an incident of resident to resident sexual abuse that occurred on a specified date indicated that the licensee was informed that a similar incident had occurred five days earlier.2 staff witnessed resident to resident sexual abuse between Resident #2497 and Resident #11. The staff reported the incident immediately to the charge nurse. Review of clinical documentation and interviews with the Administrator and the Director of Care confirmed the incident was not reported to the licensee, MOHLTC and the police as directed by the licensee's policy.

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 home's policy on "Zero Tolerance of Abuse and Neglect" is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of of the home has his or her personal items labelled.

The initial tour of the home on February 19, 2014 and subsequent random observations indicated:
-a shared washroom was noted to have 2 hair brushes and a tooth brush that had been used and not labelled.
-a second shared washroom was noted to have a hair brush and a toothbrush that had been used and not labelled.
-Inspector #552 identified in a third and fourth shared washroom, there were used hairbrushes that were not labelled and in two additional shared washrooms, used urine collectors (hats)that were not labelled.
-Inspector #111 observed in one main tub room had one used comb and nail clipper that was not labelled.

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 all residents in the home have his or her personal items labelled, to be implemented voluntarily.

WN #5: 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. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

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 failed to provide a falls prevention and management program that included strategies to reduce or mitigate falls, including monitoring of residents and review of the residents' drug regimes.

Review of the homes policy "Resident Falls" (CS-12.1) (Revised January 2013) indicated under purpose:
-to ensure appropriate steps are taken to investigate each fall and potential causative factors
-to provide a process that will ensure all factors that may have contributed to a fall are considered
-to provide a comprehensive guidelines for investigation, communication and follow up after a resident experiences a fall
-to ensure that those who have fallen are provided care in accordance with their needs.

This policy did not provide:
-strategies to reduce or mitigate falls, including monitoring of residents (screening assessments),
-the review of residents drug regimes,or
-the implementations of restorative care approaches.

2. The licensee failed 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.

Review of clinical records for Resident #2526 indicated on a specified date, the resident sustained a fall and there was no documented evidence of a post-fall assessment completed.

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 licensee has a falls prevention program that includes strategies to reduce or mitigate falls, and when residents sustain a fall, the residents are assessed using a clinical appropriate assessment tool specifically designed for falls, to be implemented voluntarily.

WN #6: 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 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.

Review of the progress notes for Resident #2514 indicated on a specified date the resident sustained a fall resulting in injuries and complained of pain for a period of 4 days. The resident was then transferred to hospital for assessment and was diagnosed with an injury.

Review of the Medication Administration Records(MARS)for Resident #2514 post fall indicated the resident only received routine analgesic four times daily (both prior and post-fall). There was no indication of any other analgesic given despite the resident's continued complaints of pain.

Interview of Staff #105 and Staff #102 indicated that a pain assessment tool is to be completed for resident's complaining of pain, for new wounds and post-falls.

Review of Resident #2514 pain assessment (completed the day after the fall)indicated "no pain". There was no documented evidence of any other pain assessments completed despite the resident's continued complaints of pain.

2. Review of the health care records for Resident #2524 indicated the resident developed a wound and the resident had verbalized ongoing pain related to the wound.

There was no documented evidence of a Pain Assessment Tool completed for Resident #2524.

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's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. Related to log#O-000101-14:

The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) was immediately notified upon becoming aware of a witnessed incident of resident to resident sexual abuse.

Review of the homes investigation for an incident of resident to resident sexual abuse that occurred, the licensee was informed that a similar incident occurred 12 days earlier. The earlier incident was witnessed by 2 staff who reported the incident immediately to the charge nurse.

Review of clinical documentation and interviews with the Administrator and the DOC confirmed the second incident of resident to resident abuse was reported to the SDM but not the first incident.

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 residents' SDM are notified immediately of becoming aware of any alleged, suspected or witnessed incidents of abuse, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Related to Log# O-000101-14:

The licensee failed to ensure that the appropriate police force was notified of a witnessed incident of resident to resident sexual abuse.

Interview with the Administrator confirmed that the police were not notified of the witnessed incident of resident to resident sexual abuse that occurred.

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 appropriate police force is notified immediately of any alleged, suspected or witnessed incidents of abuse which may constitute a criminal offence, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the Director was immediately notified of an incident that causes injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition.

Review of the progress notes for Resident #2514 indicated the resident sustained a fall and was subsequently transferred to hospital for assessment resulting in a significant change in condition. fracture.

Interview of the DOC indicated a Critical Incident (CI)report was initiated but was never submitted to the Director.

2. The licensee failed to ensure that a report was made to the Director within 10 days of becoming aware of the incident when a resident was taken to hospital resulting in a significant change in condition.

Interview of the DOC indicated a CI has still not been submitted at the time of the inspection.

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 Director is notified immediately of an incident that causes injury to a resident and results in a significant change in condition for which the resident is taken to hospital, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was monitored while restrained at least every hour by a member of the registered nursing staff, or by another member of staff as authorized by the registered nursing staff.

Observation of Resident#2526 indicated the resident had a restraint in place on three separate days.

Interview of Staff #102 and #104 indicated that the restraint was being used and that they were uncertain if the resident was being monitored on a "restraint form".
Interview of Staff #105 stated "the resident is possibly being monitored and the form should be located in the flow sheet binder".
Interview of Staff #106 and #107 indicated they were not aware that the resident's retraint was being monitored.

Review of clinical health records for Resident # 2526 indicated there was no documented evidence of a Monitoring Record to ensure the resident is monitored and repositioned when the restraint is in use.

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 residents with restraints in use are monitored at least hourly by a member of the registered nursing staff or by another member of staff as authorized for by the registered nursing staff, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the medication cart remained secured and locked while in an area other than the locked medication room.

Review of the home's policy "Section 3- The Medication System" (policy 3-5)(revised February 2012) indicated:
-the medication cart is to be locked at all times: except when in a locked medication room or while in sight of a nurse during a medication pass.

Observation of a morning medication pass on a specified date, it was noted that Staff #101 left the medication cart unlocked and unattended. On the same day during the noon medication pass, it was again observed by Staff #101 leaving the medication cart unlocked and unattended.

Observation of medication pass observed on a separate day during a morning medication pass, Staff #105 was observed entering three separate resident room's and the medication cart was left unlocked and unattended. It was also observed during a mid-morning medication pass, Staff #105 entered another resident's room, again leaving the medication cart unattended and unlocked. It was also observed at that time that there were wandering, cognitively impaired residents around the medication cart.

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 drugs are stored in an area or medication cart that is secured and locked, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to to ensure the resident's rights were fully respected and promoted in respect to being cared for in a manner consistent with his or her needs.

Review of the progress notes for Resident # 2514 indicated on a specified date, the resident was found on the floor in the doorway of another resident's room resulting in injury. The resident also complained of pain and was resistive to ROM for period of 4 days before the resident was taken to hospital for assessment and was diagnosed with a significant change in condition.

The resident did not receive care consistent with their needs for a period of 4 days.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Related to Log# O-000101-14:

The licensee failed to ensure that when they had reasonable grounds to suspect abuse of a resident occurred, immediately report the suspicion and the information upon which it is based to the Director.

Review of the homes investigation for an incident of resident to resident sexual abuse that occurred indicated that a similar incident had occurred at an earlier date. The investigation indicated that 2 PSW's witnessed and immediately reported to the charge nurse the second incident of sexual abuse between Resident #2497 and #11.

Review of clinical documentation for #2497 and #11, and interview of the Administrator and DOC, confirmed the second incident of resident to resident sexual abuse that occurred was not reported to the Director.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class(RNEC).

Observation of Resident #2526 on a specified date indicated the resident was sitting in a wheelchair which was in a tilted position.

Interview of Staff #104, #106 and #107 related to the use of the tilted wheelchair for Resident #2526 indicated that the tilted wheelchair was being used for the resident as a restraint and/or PASD for a period of two weeks.

Review of Resident#2526 clinical records indicated there was no documented evidence of a physician or RNEC order for the tilted wheelchair but a verbal physician's order was obtained as a result of the inspection.

2. The licensee failed to ensure that the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Review of Resident# 2526 clinical records indicated there was no documented evidence that consent was received for the use of the tilted wheelchair but verbal consent was obtained by the resident's SDM as a result of the inspection.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
  i. a physician,
  ii. a registered nurse,
  iii. a registered practical nurse,
  iv. a member of the College of Occupational Therapists of Ontario,
  v. a member of the College of Physiotherapists of Ontario, or
  vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to obtain consent for the use of a PASD by the resident or if the resident is incapable, by the substitute decision-maker with the authority to give the consent.

On a specified date, Resident #2494 was observed using a PASD while seated in the wheelchair.

Review of progress notes of Resident #2494 for a three month period, indicated the resident had the PASD in place to prevent future falls and was to be used in bed and/or in the wheelchair at all times.

Interview of Staff #102 indicted the PASD was used to prevent falls.
Interview of Staff #108 indicated Resident #2494's PASD had been in place for approximately 2 months, and is applied for safety.

Review of the health care records for Resident #2494 indicated there was no documented evidence of a consent for the use of the PASD but a verbal consent was obtained by the resident's SDM as a result of the inspection.

WN #16: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents admitted to the home were screened for Tuberculosis(TB) within 14 days of admission, unless the resident had already been screened in the 90 days proceeding the admission, and the documented results of the screening was available to the licensee.

Review of health records indicated:
-Resident #12 had TB screening completed greater than 14 days after admission and had no documented evidence of prior screening within 90 days of admission.
-Resident #13 had no documented evidence of TB screening.
-Resident #14 had TB screening completed greater than 14 days after admission and had no documented evidence of prior screening within 90 days of admission.

2. The licensee failed to ensure that all residents admitted to the home were offered immunizations against pneumoccocus, tetanus, and diptheria in accordance with the publicly funded immunization schedule.

Review of health care records indicated:
-Resident #12 had consented to receiving pneumovax, tetanus and diptheria but no indication of immunization provided.
-Resident #13 had consented to receiving tetanus and diptheria but no indication of immunization provided.
-Resident #14 had consented to receiving tetanus and diptheria but no indication of immunization provided.

Issued on this 31st day of March, 2014

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

L Brown

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

Ministère 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), CAROLINE TOMPKINS (166), MARIA FRANCIS-ALLEN (552), MATTHEW STICCA (553)
Inspection No. / No de l'inspection :	2014_220111_0005
Log No. / Registre no:	O-000127-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 6, 2014
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	SPRINGDALE COUNTRY MANOR 2698 CLIFFORD LINE, R. R. #5, PETERBOROUGH, ON, K9J-6X6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MAUREEN IMAMOVIC

To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is required to submit and implement a plan of corrective action related to the following:

1) The licensee shall review and revise the written plan of care for Resident#2494 related to the provision of care and interventions for oral hygiene to ensure clear direction is provided.

2) The licensee shall review and revise the written plan of care for Resident #2524 currently identified as exhibiting wounds to ensure the plan of care provides clear direction related to those wounds and interventions to manage the risks associated with altered skin integrity.

3) The licensee shall review and revise the written plans of care for Resident #2526 currently identified with a restraint in use and Resident #2494 currently identified with a Personal Assistive Safety Device (PASD) in use to ensure the plans of care for those residents provides clear direction related to the use of the restraint and PASD, and interventions to minimize the risk associated with these devices.

4) The licensee shall review and revise the written plan of care for Resident #2524 currently identified as experiencing pain to ensure the plan of care provides clear direction related to the type, location and frequency of the pain and appropriate interventions to reduce or eliminate the pain.

5) The licensee shall retrain all nursing staff regarding ensuring there is a written plan of care for each resident that provides clear direction to staff and others who provide direct care in the provision of care and interventions to manage the risks related to oral hygiene, restraints/PASD's, skin and wound management, and pain.

The plan is to be submitted to Lynda Brown via email to: Lynda.Brown2@ontario.ca by March 17, 2014.

Grounds / Motifs :

1. 1. The licensee was issued non-compliance related to LTCHA, 2007, s.6(1)(c) on October 28, 2013 during inspection # 2013_195166_0040.

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

and PASD's:

Observation of Resident #2494 indicated a PASD was applied to the resident;
-Review of the progress notes for Resident #2494 indicated the resident was to have the PASD in use at all times to help reduce the risk of a fall.
-Interview of Staff #108, indicated the resident had been using the PASD for safety while in the wheelchair and bed for a period of greater than 2 months.
-Review of the plan of care for Resident #2494 had no indication of a PASD in place.

The licensee failed to ensure that the plan of care set out clear directions to staff and other who provide direct care to the resident related to oral hygiene:

Review of the health care record for Resident #2494 indicated:
-Review of PSW's flow sheets related to oral care for a 4 month period indicated their were 52 documented incidents when the resident did not receive oral care. 26 out of the 52 times was due to "R".
-Interview of Staff #109 and #110 indicated "when there is an "R" on the PSW flow sheet it means the resident would have refused oral care and that oral care would not have been completed". Staff #110 indicated Resident #2494 "has been known to become aggressive with staff when oral care is attempted".
-Review of the plan of care during that same time period related to oral care indicated interventions as daily cleaning of teeth or dentures, daily mouth care by client or staff, 1 staff to provide total assist with mouth care due to medical conditions, staff to monitor oral cavity for any lesions, open areas, etc.(and report any concerns to registered staff),staff to place tooth paste on toothbrush and hand to the resident and then request the resident to brush their own teeth,and if the resident refuses to complete, staff to perform care for them.

There was no clear direction whether the resident had teeth or dentures (or both). It was unclear whether staff was to perform the activity or the resident, and the direction given for when the resident refuses, contradicted the original direction. (553)

2. 3. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to skin and wound care:

Review of the health care record for Resident #2524 indicated:

-The progress notes indicated the resident developed skin breakdown and another skin care issue to another area. 6 days later,the skin breakdown deteriorated in condition.13 days later, developed a third skin care issue.
-Review of RAI-MDS for Resident #2524 indicated under Pressure ulcers indicated: the resident is high risk for skin breakdown related to bed mobility problem and bowel/bladder incontinence, uses pressure relief devices, and "has no skin breakdown".
-Review of the plan of care for Resident #2524 indicated altered skin integrity (pressure ulcers).Interventions included offering nutritional intervention as ordered to promote wound healing and on supplements with added protein but meal intake is poor.
-There was no clear direction related to all areas of altered skin integrity and appropriate interventions to manage the risks associated with altered skin integrity. (111)

3. There was no clear direction on the plan of care regarding a restraint that was in use and no interventions to manage the risks associated with restraints.

Observation of Resident #2526 indicated the resident had a physical restraint in place;
-Interviews of Staff #102, #104, #105, #106 and #107 all had conflicting responses related to the use of the restraint.
-Review of the care plan related to Resident #2526 does not indicate that the resident used a restraint,
-The "Resident's Requiring Restraints" list did not include Resident # 2526 as using a restraint. (552)

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

Review of the progress notes for Resident # 2524 indicated:
-the resident developed two pressure areas and two days after developing the pressure areas, the resident developed intense pain as a result.The resident continued to complain of pain for a period of 6 days.
-Review of the Medication Administration Record (MAR)during the same period of time indicated the resident had routine narcotic analgesic ordered and narcotic analgesic ordered for breakthrough pain. During the period the resident demonstrated pain related to the pressure area, the resident only received breakthrough analgesic on two instances.

-Review of the plan of care for Resident #2524 related to comfort indicated the resident had both constant and occasional moderate pain related to immobility.The interventions included administering medication as ordered and assess effectiveness;assess the residents pain for a set number of days to establish any patterns.
-There was no clear direction related to the "location of pain", whether the resident had "occasional" or "constant pain". There was also no clear direction how staff would "assess effectiveness" or what "a set number of days" referred to.

Review of the clinical health records for Resident # 2514 indicated:
-Progress notes indicated the resident sustained a fall resulting in the resident complaining of pain and was resistive to range of motion (ROM)for a period of 5 days.
-The resident was not taken to hospital for a period of 5 days post fall and was diagnosed with an injury.
-Review of the resident's "Pain Assessment and Evaluation Tool" (completed the day after the fall) indicated the resident had "no pain". There was no documented evidence of any further pain assessment tools completed.
-Review of the MAR for the period before and after the fall indicated the resident received routine analgesic four times daily. There were no other medications available for breakthrough pain and no indication the resident received any other analgesic when the resident continued to complain of pain.
-Review of the care plan post fall for Resident # 2514 related to comfort indicated a potential for discomfort related to a previous injury.Interventions included: mild pain, analgesic four times daily and staff to monitor for pain and discomfort during care and report any changes to registered staff.
-There was no clear direction related to the location of the resident's pain or appropriate interventions to manage the resident's increased pain related to the new diagnosis of an injury.
(111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee is required to submit and implement a plan of corrective action related to the following:

1) The licensee shall ensure that Resident #2514 and #2526 who are at risk for falls are reassessed and the plan of care reviewed and revised according to the resident's assessed care needs.

2) The licensee shall retrain all nursing staff regarding ensuring there is a written plan of care for each resident that is based on reassessment of their needs, when their care needs change, or are no longer necessary in the provision of care and interventions to manage the risks related to falls.

The plan is to be submitted to Lynda Brown via email at Lynda.Brown2@ontario.ca by March 17, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to risk of falls.

Review of the health care record for Resident #2514 indicated:
-the Progress notes indicated the resident was found on the floor in the doorway of another resident's room on a specified date and was subsequently diagnosed with an injury. Approximately 2 1/2 months later, the resident sustained a second fall.
-The post fall assessment completed after the first fall indicated the action plan was to complete head injury and every 15 minute checks. The post fall assessment after the second fall indicated the action plan was to complete every 15 minute checks for one month and complete head injury.
-The care plan indicated the resident was a high risk for falls related to unsteady gait.
-There was no indication when the resident was reassessed, the plan of care was revised to indicate the resident had a history of falls (resulting in injury) and the resident was to be on every 15 minute checks x1 month post falls.

Review of the health care record for Resident # 2526 indicated:
-Progress notes indicated the resident sustained two falls approximately one month apart.
-RAI/MDS post falls indicated under J4 (accidents) "no falls/fractures in past 30 days or 31 to 180 days".
-the resident list for "high risk for falls" did not include Resident #2526.
-the nursing quarterly summary indicated the resident was at high risk for falls but did not provide any interventions to address the resident's risk for falls.
-the care plan identified the resident as high risk for falls but no interventions were documented.

The licensee was issued non-compliance to LTCHA, 2007, s. 6(10)(b) on October 28, 2013 during inspection# 2013_195166_0041. (552)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6th day of March, 2014

Signature of Inspector / Signature de l'inspecteur : L Brown

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

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