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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 4, 2015	2015_30610a_0011	H-002777-15	Resident Quality Inspection

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

VALLEY PARK LODGE
6400 VALLEY WAY NIAGARA FALLS ON L2E 7E3

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

IRENE SCHMIDT (510a), BARBARA NAYKALYK-HUNT (146), CAROL POLCZ (156), KELLY CHUCKRY (611), PHYLLIS HILTZ-BONTJE (129), ROBIN MACKIE (511)

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): June 25, 26, and 29, 2015 and July 6,7,8,9,10, 13 and 14, 2015

Critical Incident #007707-14 (H-001598-14) was inspected as part of this RQI. Complaint #001433-14 (H-000872-14) was severed and inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Director of Care (DOC), Resident Assessment Instrument (RAI)Coordinator, registered staff, personal support workers, social worker, recreation staff, maintenance staff, dietary staff, residents, families, Residents' Council President, and Family Council President.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

12 WN(s)
9 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 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of a resident were fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On an identified date, a specific resident, was observed in a common area to be wearing a shirt and a blanket wrapped around their waist. During a specific time frame, the resident was observed to inadvertently kick off the blanket several times, exposing themselves to other residents. A review of the clinical record confirmed the resident required total assistance from one staff to ensure they would be appropriately dressed. Registered staff confirmed that the dignity of the identified resident was not respected when they became exposed to other residents in common areas. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential, in accordance with that Act.

On an identified date, a scrap piece of paper was found inside the chart of a specific resident. The reverse side of this piece of paper contained personal health information (PHI) for a different identified resident, including name and medications. The Acting DOC confirmed the above and that paper used for scrap should not contain PHI. The PHI of for the identified resident was not kept confidential. [s. 3. (1) 11. iv.]

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 every resident:
1. is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. has their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, 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. The licensee has failed to ensure that where the Act or this Regulation required the licensee to have, institute or otherwise put in place any policy, protocol or strategy that the policy, protocol or strategy was complied with. [8(1)(b)]

A) The home policy "CN-C-24-1 Clothing" dated May 2011 directed that "should any item of resident's clothing be missing, the laundry will be notified and attempt to locate the same". A "Missing clothing checklist" was attached.
During stage one of the inspection, an identified resident voiced concern over missing clothing. There was no documentation of the missing item in the laundry department and the Administrator was not aware of the missing item. A review of the progress notes for this resident indicated that on an identified date, the resident was missing the clothing. This was consistent with what the resident reported to the inspector during stage one of the inspection. On an identified date, the resident reported that the clothing was still missing. Interview with the Administrator confirmed that the policy was not complied with. It was confirmed that a checklist should have been completed and the home should have tried to find the missing item but there was no record of this being done and the item remained missing.
B) Policy #6.6 titled "Narcotic and Control Drug Count and Ward Count" directed that "all narcotic and controlled medications must be accounted for at the end of each shift. Both the nurse handing over (Nurse one) and taking over (Nurse two) will sign with the date and time".
On an identified date and time, a review of the daily count sheets revealed several blank spaces for the count. Of the top eight 'Resident's Narcotic/Controlled Drug Count and Ward Count' sheets, six had not been signed by Nurse one and Nurse two, as written in the policy. The Acting DOC and the Administrator confirmed it is the expectation of the home that the count be completed and signed for by two registered staff as directed in

the policy. The home's policy was not complied with. (510)
C) Staff in the home did not comply with directions contained in the home's Responsive Behaviour Management policy identified as #CN-B-04-1 and dated June 2010 which directed that where ever possible the triggers to behaviour are identified on the plan along with any strategies or interventions to respond to the behaviour.
i) An identified resident was noted to demonstrate particular behaviours. Staff and clinical documentation confirmed that there was not an attempt to identify triggers for this behaviour and there were no strategies included in the plan to respond to this behaviour.
ii) An identified resident was noted to demonstrate particular behaviors. Staff and clinical documentation confirmed that there was not an attempt to identify triggers for this behaviour and there were no strategies included in the plan to respond to this behaviour. (129) [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any policy, protocol or strategy that the policy, protocol or strategy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

A) An identified resident was observed on four occasions during a specified period, to have dirty fingernails. A Personal Support Worker (PSW) provided morning care to this resident, however their nails were not cleaned. The identified resident did not receive individualized personal care, including hygiene care and grooming on a daily basis, specifically related to the provision of nail care. The DOC confirmed it is the home's expectation that nails are cleaned daily with care.
B) An identified resident was observed on four occasions during a specified period, to have long, dirty fingernails. The resident expressed concern to staff that their nails needed to be cleaned. A PSW confirmed the nails were in need of grooming and escorted the resident to provide this care. The DOC confirmed it is the home's expectation that resident's nails are cleaned daily, with care.
C) An identified resident was observed on three occasions during a specified period to have long fingernails beyond the fingertips. The resident identified the need to have their fingernails trimmed. The resident did not receive individualized personal care, including hygiene care and grooming on a daily basis, specifically related to the provision of nail care. The DOC confirmed it is the home's expectation that nails are trimmed on bath days and as necessary. [s. 32.]

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 each resident of the home receives individualized, personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that (b) at least annually, the matters referred to in subsection (1) were evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. O. Reg. 79/10, s. 53 (3).

The Administrator confirmed that the document provided by the home to demonstrate the annual review of the Responsive Behaviour Program did not include:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social. environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviors

3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources, where required. [s. 53. (3) (b)]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviors behavioral triggers were identified, where possible and strategies were developed and implement to respond to the behaviors, in relation to the following: [53(4)]

A) The licensee did not attempt to identify behavioral triggers for responsive behaviors being demonstrated by two identified residents.
i) Staff and clinical documentation confirmed that an identified resident began demonstrating specific behavior when it was documented on a Resident Assessment Instrument-Minimum Data Set (RAI-MDS) completed on a specified date, that the resident demonstrated this behavior on one to three days out of seven days. Staff and clinical documentation confirmed that there was not an attempt made to identify triggers for this specific behavior.
ii) Staff and clinical documentation confirmed that an identified resident began to demonstrate specified behavior when it was documented on a RAI-MDS completed at a particular time that the resident demonstrated specified behavior almost daily. The specific behavior was not identified on the Resident Assessment Protocol (RAP) that was completed at this time. Staff and clinical documentation confirmed that there was not an attempt made to identify possible triggers for the specific behavior.
B) The licensee did not develop and implement strategies to respond to the responsive behaviors being demonstrated by resident two identified residents.
i) Staff and clinical documentation confirmed that strategies were not developed and implemented for specified behaviors being demonstrated by an identified resident. Staff confirmed that the document used by the home to identify care strategies to be provided to the resident did not contain information about the specified behavior or strategies to manage the behavior.
ii) Staff and clinical documentation confirmed that strategies were not developed and implemented for specific behaviors being demonstrated by an identified resident. Staff confirmed that the specific behavior was not identified and the document used by the home to identify care strategies did not contain directions for staff in the management of the specific behaviors. [s. 53. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
1) at least annually, the matters identified in the finding are addressed in the annual review of the responsive behavior program and
2) for each resident demonstrating responsive behaviors, behavioral triggers are identified, where possible, and strategies are developed and implemented to respond to the behaviors, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

On an identified date, two identified residents engaged in a physical altercation. The clinical record reported that one of the residents was known to demonstrate specific behaviors in identified situations (triggers). The clinical record and the Administrator confirmed there were no interventions implemented, related to the specific trigger, to minimize the risk of altercation and potentially harmful interactions between the identified resident and other residents. [s. 54. (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 to ensure steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: 4. Monitoring of all residents during meals.

On observation at an identified time in the dining room, a particular number of residents were observed to be sitting in front of their plate containing varied amounts of food and drink, unsupervised. The staff were observed to be transferring residents out of the dining room and leaving the dining room unattended for several minutes at a time. The residents were noted to have varied levels of cognitive function and several residents were noted to be eating off of their plates. An interview with the RN on the floor confirmed the home's practice was to ensure supervision of all residents during meals, even at the end of a meal, by having at least one staff member in the dining room and that the home did not ensure the residents were monitored during their meal when all staff left the dining room during portering. [s. 73. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, monitoring of all residents during meals, to be implemented voluntarily.

WN #7: 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. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

On an identified date and time, an identified resident was observed sitting in a Broda chair with a lap belt in place. The lap belt was twisted and loose and hanging to the mid-upper leg. The registered staff was alerted and confirmed that the belt was a restraint and that it was looser than two finger breadths from the body. Registered staff confirmed the restraint was not applied in accordance with the manufacturer's instructions. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure restraints are applied according to the manufacturers instructions, to be implemented voluntarily.

WN #8: 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, (a) drugs were stored in a medication cart that was secured and locked.

On an identified date and over a particular time period, the medication cart was observed outside the dining room, being left unlocked, unsecured and unattended while the Registered Practical Nurse (RPN) administered medications to the residents in the dining room. During the administration of the medication, the RPN was observed to have their back to the cart, walk down a hallway and around a corner to a resident's room with the medication cart out of their sight and unsupervised for several minutes at a time. Interview with the RPN confirmed the medication cart was to be locked at all times when unattended. [s. 129. (1) (a) (iii)]

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 a medication cart that is secured and locked, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including the following: 1. All areas where drugs are stored shall be kept locked at all times, when not in use.

On an identified date, topical prescription medications were found in bins on the counter of a small room at the nurses station. Registered staff advised this was where topical prescription medications were stored as it facilitated access to the medications by the PSW's who applied the topical medications. Registered staff confirmed the door to the room was left unlocked.
The administrator confirmed the door to the room where prescription topical medications were stored was found unlocked and should be locked at all times. [s. 130. 1.]

2. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply, including the following: 3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

On an identified date, the ADOC advised she was unable to find a record of monthly audits of the daily count sheets of controlled substances. On another identified date, the Administrator confirmed there was no record available of the above monthly audits. A monthly audit of the daily count sheets of controlled substances was not completed, to determine if there were any discrepancies. [s. 130. 3.]

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 steps are taken to ensure the security of the drug supply, including:
1. all areas where drugs are stored are kept locked at all times, when not in use, and
2. a monthly audit is completed of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #10: 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 has failed to ensure that the use of the PASD bed rails had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

An identified resident was noted to use a personal assistance services device (PASD) of two quarter bed rails, however, the consent was not signed by the Power of Attorney (POA) as confirmed with registered staff and the ADOC on July 10, 2015. [s. 33. (4) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

The Minimum Data Set (MDS) assessment with a specified date, indicated that an identified resident had experienced increased frequency of pain. Review of assessments for the resident revealed two pain assessments, 6 months apart, and no pain assessment for the time the resident's pain was reported to be changing. The ADOC confirmed that a pain assessment using a clinically appropriate assessment instrument had not been completed when the resident's pain had changed. [s. 52. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs; O. Reg. 79/10, s. 134.

An identified resident received routine medications for pain as well as medications as necessary (prn), if the resident required additional relief. Review of medication administration records (MAR) for a specified period of time, revealed that the resident received prn medication a particular number of times. Effectiveness of the medications was not documented on the MAR for any of these medication administrations. On a particular number of occasions, a note regarding effectiveness of the medication was not found in the progress notes. Registered staff and the ADOC confirmed the above. The effectiveness of the medications administered was not documented. [s. 134. (a)]

Issued on this 10th day of August, 2015

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

Original report signed by the inspector.