Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 5, 2021	2021_575214_0003	010329-20, 000420-21	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way Thorold ON L2V 4T7

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

The Woodlands of Sunset
920 Pelham Street Welland ON L3C 1Y5

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

CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 3, 4, 5, 8, 10, 11, 12, 17, 18, and 22, 2021, on site and February 9 and 16, 2021, off-site.

Please note the following:

This inspection was conducted simultaneously with CIS Inspection #2021_575214_0004.

The following intakes were completed during this complaint inspection:

-Log # 010329-20- related to Complaint Response.

-Log #000420-21- related to Prevention of Abuse and Neglect; Skin and Wound; Hospitalization and Change in Condition.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Resident Care (DRC); Registered Nursing Staff; Nurse Practitioner (NP) and Personal Support Workers (PSW).

During the course of the inspection, the inspector reviewed clinical health records; identified policies and procedures; reviewed electronic mail (Email) correspondence; complaint log and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

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:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
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. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a pain management program to identify and manage residents' pain, was developed and implemented in the home.

A Critical Incident System (CIS) report indicated that a resident was reported to have pain to a specified limb. During the span of five days, the resident was noted to have altered skin integrity and newly developed symptoms to the identified limb, resulting in the identification of an injury and the resident being sent for treatment.

The licensee’s pain policy stated specific times a formal pain assessment was required to be completed, including which forms to use. The policy directed staff to address specified qualities of pain, effects the pain had on residents daily activities, and any comfort measures that were effective in managing the pain. The policy identified the home's medication administration system automatically triggered an assessment for registered staff to measure the intensity of a person's pain, when an analgesic was administered.

Review of the resident’s clinical records indicated there were three incidents where staff identified pain in the resident. Registered staff confirmed no further pain assessments had been conducted regarding the nature, quality, and duration of the resident's pain or if the resident was unable to verbalize responses, no assessments or documentation of any non-verbal signs of pain or symptoms.

The clinical records indicated registered staff were to assess an alteration to the resident's skin integrity. On two consecutive dates, staff documented they were unable to complete this; however, the manner in which this was documented, had not allowed in coming staff to follow up.

The DRC confirmed the Pain policy listed above, was the only document contained in the home's Pain Management Program. The Administrator and DRC confirmed the policy had only included direction for the assessment of a resident's pain at specified times and had not provided direction for assessment of a resident's pain that occurred outside of these parameters. The DRC indicated that staff should have conducted a specific progress note type whenever a resident verbalized or demonstrated signs or symptoms of pain and this had not been completed.

The Administrator and DRC confirmed staff at the start of their shift, were expected to print a progress note report from the documentation system, and review for any required follow up. The Administrator and DRC confirmed they were unable to view specified types of progress notes when accessing the resident's progress notes from their profile or when printing a progress note report. It was noted that the documentation system was able to create progress note reports in different ways, and that not all reports contained the specified type of progress notes.

The DRC indicated the home had no policy in relation to the use of the eMAR and eTAR systems used in the home. The DRC indicated registered staff were verbally trained in the home on these systems. The DRC indicated the alert feature on the eMAR/eTAR was only capable of being enabled for a nursing measure where an assessment was required to be completed and that this feature is not available for use when it applied to a medication that had been administered. The DRC indicated when the resident's altered skin integrity was unable to be assessed on two specified dates, the staff were to have checked the alert feature which would have prompted incoming registered staff to follow up. The DRC indicated when staff are unable to determine the effectiveness of a medication they administered, they should not select the "unknown" option on the eMAR, as when they do, this turns the order to a green colour indicating the order is completed and would not allow the staff or incoming staff to follow up on the effectiveness. When staff do not select the "unknown" response on the order, this turns the order to a pink colour, and prompts the staff or incoming staff to follow up on the effectiveness. The DRC indicated the system should only contain the options for the assessor to identify if the medication or treatment was "E-effective", or "I-Ineffective".

The Administrator and DRC confirmed the home's pain management program had not been developed as no direction was provided to assess a resident's pain outside of the policy parameters, had not provided a policy or written direction for use of the eMAR and eTAR systems or the requirement of incoming registered staff to print and review a progress note report for the purpose of follow up, including how to print this report so that all entries were visible.

When the pain management program is not fully developed, there is a risk of not providing direction to staff who are responsible to participate in the program and as a result, places resident's at risk of not having their pain fully assessed, interventions appropriate to their needs implemented, effectiveness of interventions monitored and an effective plan of care for pain management established.

Sources: critical incident system (CIS) report, complaint intake, home's pain policy, resident's progress notes and eMAR and eTAR records, and interview with RPN and other staff. [s. 48. (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 a pain management program to identify pain in residents and manage pain, is developed and implemented in the home, to be implemented voluntarily.

WN #2: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of their plan of care.

A resident had identified symptoms to a specified limb. A diagnostic test was ordered and indicated the resident had an injury and was sent for treatment.

The resident’s physician was called regarding the residents symptoms and a diagnostic test was ordered. The progress note contained an area to document if consent for treatment/medication was received from the resident; Substitute Decision Maker (SDM) or the Power of Attorney (POA). No documentation was in place to indicate if consent had been obtained or not. A review of progress notes up to and including the date and time the diagnostic test was conducted, indicated no documentation was recorded that the SDM or POA had been notified of the test.

A RN confirmed that the resident’s SDM had not been notified of the ordered test and was not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Sources: critical incident system (CIS) report, complaint intake, resident’s progress notes and plan of care records, and interview with RN. [s. 6. (5)]

Issued on this 17th day of March, 2021

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

Original report signed by the inspector.