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

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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
Aug 15, 2014	2014_292553_0026	629-13,1070-13	Critical Incident System

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

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

CARESSANT CARE LINDSAY NURSING HOME
240 MARY STREET WEST, LINDSAY, ON, K9V-5K5

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

MATTHEW STICCA (553)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 12-13, 2014

Logs # O-000629-13 and O-001070-13 were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Nursing (DON), Resident Care Coordinator (RCC), RAI Coordinator, Assistant RAI Coordinator, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) toured the home, reviewed clinical health records, reviewed the home's post fall investigations, reviewed the home's policies on "Lifting a Fallen Resident", "Treatment Protocol-Skin Tear", "Interdisciplinary Skin Care Management Team", "Safe Lifting Responsibilities for all Employees", "Safe Lifting: Use of Transfer Belts" and "Pain Assessment"

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Pain
Personal Support Services
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 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. Regarding log # 629-13

The licensee has failed to ensure that when Resident #2's pain was not relieved by initial interventions, that Resident #2 was assessed using a clinically appropriate

assessment instrument specifically designed for that purpose.

Summary of incident involving Resident #2:
-Resident #2 was reported to have a fall on a specified date. Assessment of Resident #2 indicated no injuries.
-On a specified date Resident #2 was complaining of pain and requested to go to the hospital for assessment.
-On a specified date the home received a call from the hospital indicating that Resident #2 was to be admitted.
-On a specified date Resident #2 returned to the home, Resident #2 passed away in the home 5 days later.

Review of Resident #2's annual MDS assessment completed on a specified date prior to Resident #2 experiencing their fall.

Resident #2 was assessed as being able to communicate with others in the home.
Resident #2 was assessed as having no pain.

Review of progress notes from a specified time period indicated:

Resident #2 was reported to have a fall. Resident #2 experienced an increasing level of pain after sustaining their fall. Resident #2 was transferred to hospital due to the increasing level of pain. Upon returning to the home, Resident #2 continued to report an increasing level of pain. The home administered prescribed medications to Resident #2 as required for pain control. Despite the home's use of the prescribed medications, Resident #2 pain was not under control. In response to this, the home acquired new analgesics that would address the increasing amount of pain that Resident #2 was experiencing. Over the specified time frame from when Resident #2 experienced a fall to when they passed away Resident #2's pain was continually increasing as evidenced by the home obtaining 3 narcotic based analgesics that were to be given as required for pain control.

Interview with RN #111, RPN #110 and RPN #105 on August 13, 2014:
RPN #110 indicated that a pain assessment tool is to be completed when there is a change in condition, or status of a resident and that a pain assessment tool is completed upon admission and quarterly. RPN #110 indicated that a "pain management flow record" will be placed in the narcotic binder to monitor the

effectiveness of new medications ordered for pain relief.
RN #111 and RPN #105 both indicated that the "pain management flow record" is placed in the narcotic book to monitor effectiveness of new narcotics that are used for pain relief. RN #111 and RPN #105 stated that pain assessment tools are completed quarterly through MDS as well as a "Caressant Care Pain Assessment Tool" form available on point click care.

In review of Resident #2 clinical health records, there was no documented evidence of a "Caressant Care Pain Assessment Tool" being completed in the calendar year of their death. The last pain assessment was completed prior to Resident #2's fall on a RAI MDS Annual Assessment where Resident #2 was assessed as having "no pain". Resident #2 reported an increasing amount of pain prior to transfer to hospital, this pain continued after Resident #2 returned from hospital and subsequently the pain worsened. Resident #2's condition had changed since the MDS Annual Assessment as evidenced by Resident #2's new and increasing pain. For this new pain, Resident #2 received new orders for 3 different narcotic based analgesics. There was no documented evidence of a "Caressant Care Pain Assessment Tool" initiated for any of the dates listed or a "Pain Management Flow Sheet" to monitor the effectiveness of the new pain medication.

On August 13, 2014, Staff #101 and Staff #109 confirmed that a pain assessment tool should have been completed for Resident #2 and Staff #109 also indicated that there should be pain management flow sheets initiated for each of the new medications started.[s. 52. (2)]

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 that 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, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.107 (3), whereby the licensee did not ensure that an injury of person that resulted in transfer to hospital was reported within one business day to the Director.

As indicated by the resident health care record, Resident #2 had a fall, the home was unable to determine if injury occurred at that time. Resident #2 had no further complaints until the morning of a specified date, where Resident #2 reported an increase in pain, as the day went on Resident #2's pain intensified and Resident #2 was transferred to hospital for assessment. The hospital informed the home that Resident #2 was to be admitted.

The Director was informed of the incident described above, through the Critical Incident System on a specified date that was not in accordance with legislative requirements.

Interview with Staff #100 on August 13, 2014:

Staff #100 spoke with the Regional Manager for the home who confirmed that at the time of the critical incident the home's practice was to have corporate offices approval and review of Critical Incident Reports prior to submission to the Director. Staff #100 indicated, that would be the reason as to why there was a delay in the submission process. Staff #100 indicated that this is no longer the practice for the home.

It is noted, that O.Reg 79/10, s.107(3) was amended as of September 15, 2013. This finding relates to an incident that occurred prior to September 15, 2013 and therefore the previous s.107 (3) was applied. [s. 107. (3)]

Issued on this 31st day of October, 2014

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