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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d’Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Nov 22, 2017	2017_694166_0027	024656-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Warkworth Place
97 Mill Street P.O. Box 68 Warkworth ON K0K 3K0

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

CAROLINE TOMPKINS (166), LYNDA BROWN (111)

Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): November 14, 15, 16, 20 and November 21, 2017

Critical Incident logs #025822-17, related to a fall and #021730-17 related to a controlled substance missing/unaccounted were inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Families, Representative of the Residents' Council, Program Director, Personal Support Workers, Physiotherapy Assistant(PTA), Registered Nurses(RN), Registered Practical Nurses(RPN), Director of Care(DOC) and the Administrator. During the course of this inspection , the inspectors toured residents' rooms and common areas. The inspectors observed resident to resident interactions and staff to resident interactions during the provision of care. Observed medication administration and infection control practices. The inspectors reviewed residents' health care records/ assessment documentation, the licensee's investigations documentation and the licensee's policies related to pain identification/management, and falls prevention/management program.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
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	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. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Interview with RPN #100 and review of the progress notes for resident #017 indicated the following related to pain:
On a specified date, resident #017, sustained a fall and indicated had no pain at that time. Two hours post fall RPN #100 indicated, resident #017 complained of pain to a specified area and an analgesic was administered to the resident. Approximately one hour after the analgesic was administered, RPN #100 indicated the medication was ineffective. There was no evidence that an assessment of the resident or other actions were taken.

During the following shift, post fall, RN #112 indicated resident #017 complained of "some discomfort" to the specified area but no other injury was noted. There was no documented evidence the resident was offered analgesic or that a pain assessment was completed at that time.
The following shift, the DOC assessed the resident and indicated the resident was guarded and experienced pain with movement. A decision was made to transfer resident #017 to the hospital for further assessment and treatment.

Resident #017 was admitted to the hospital and received interventions related to the injuries sustained during the fall.
When the resident was discharged from the hospital and returned to the home, the resident initially denied having any pain, however for six days post readmission to the home, the resident did complain of pain and was given analgesics. There was no

documented evidence that a pain assessment was conducted for resident #017 before or after analgesic administration.

Approximately twenty-eight days post fall, admission, treatment at the hospital, return to the home and administration of analgesics, a Pain Assessment was completed for resident #017.

Interview with RPN #100 by Inspector #111, indicated on the date of the fall resident #017 had complained of pain later in the shift and was given analgesic at that time. The RPN indicated the resident was still in pain post administration of analgesic and passed this information onto the next shift but no pain assessment completed.

Interview with RN #112 by Inspector #111, indicated that during the RN's shift, resident #017 complained of some pain. The RN indicated no visible injury was observed but did offer analgesic to the resident, which was refused. RN #112 did not complete a pain assessment.

Interview with RN #109 by Inspector #111, indicated RPN #109 assessed resident #017 , the next morning post fall as staff had reported the resident was not weight bearing, but was in minimal pain at that time, offered resident #017 analgesic, but it was refused. The RN indicated the NP was called and message left to call back .The RN indicated resident #017's SDM requested the resident be assessed by the NP. The RN indicated, did not receive a call back from the NP at that time but indicated RN #109 notified the DOC regarding the resident’s fall.

Interview with the DOC by Inspector #111, indicated the DOC was notified that resident #017 had sustained a fall the previous evening. The DOC assessed the resident and did not see any visible injury but made the decision to send the resident to hospital for assessment and treatment due to complaints of pain.

The DOC indicated, it is the expectation/policy that a pain assessment be completed for a resident when admitted to the home, upon return from hospital, any new pain or use of a PRN analgesic. The DOC indicated the plan of care should also be updated at any time there is a change in pain for a resident and the Medication Administration Record(MAR) should indicate level of pain score when administering a pain medication.

Review of the licensee's policy "Pain Identification and Management" (RC-19-01-01) revised February 2017 indicated: The resident is assessed for pain using the Pain Flow

Notes in PCC. A Pain flow note will be completed on all resident who meet any of the following criteria: resident states they have pain, any change in condition that has the potential to impact the resident pain level, re-admission, taking new pain-related medication for 72 hours, and taking an increased dose and/or frequency of pain related medication. Initiate the Pain Flow Record (appendix 1) for 72 hours if the resident meets the following criteria: new regular pain medication is ordered and there is a dosage increase of regular pain medication.

Review of the pain assessment for resident #017, approximately 28 days later indicated the resident had pain related to the injury sustained during the fall. The pain level measured was 5/10. The assessment indicated the pain started when the fall occurred and when the resident returned to the home, the injury had also aggravated a preexisting condition.

Review of the health record for resident #017 indicated the resident had sustained a fall on a specified date. There was no documented evidence the resident was assessed for pain using the clinically appropriate assessment tool (as indicated in the licensee's policy) when the resident developed new pain. There was also no documented evidence the resident was provided pain management despite continuing to have pain and then was transferred to hospital for assessment. There was no documented evidence the resident was assessed for pain after returning from hospital. There was no documented evidence a pain flow record was completed (as per the licensee's policy) when resident #017, received two new pain medications, continued to complain of pain and received analgesic over 72 hour period.
A pain assessment was not completed until approximately 28 days post fall. [s. 52. (2)]#111

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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident.

Review of the medication incidents over a month period indicated there were 2 incidents that involved residents. The two incidents were as follows:
1) On a specified date and time, resident #024 was not administered seven medications as prescribed. The medication incident was not reported to the Physician, SDM/resident or Medical Director. There was no evidence of a documented assessment to indicate the resident was assessed after not receiving the prescribed seven medications as directed.
2) On a specified date, resident #003 was administered the wrong medication. There was no documented evidence the Physician, resident or Medical Director were notified. There was no documented evidence the resident was assessed when the resident received medication not prescribed.

Interview with RPN #108 indicated, RPN #108 discovered his/her own med error when he/she noted he/she gave the wrong medication and dosage to resident #003. The RPN indicated he/she did not contact the physician or Medical Director but notified the resident's SDM at the time of the incident. The RPN indicated he/she did not complete or document an assessment of the resident.

The DOC indicated recalling the medication incident involving resident #003 and the Physician was notified of the medication incident approximately one week later during rounds. The DOC indicated there was no documented evidence the Physician and the Medical Director were notified of the medication incident that occurred involving resident #024. [s. 135. (1)]

Issued on this 23rd day of November, 2017

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

Original report signed by the inspector.