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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2018	2018_605213_0017	005577-17, 010956-17, 018847-17, 024398-17, 027261-17, 002557-18, 005799-18, 006471-18, 007992-18, 008413-18, 008524-18, 008760-18, 009037-18, 009644-18, 017371-18, 020585-18, 024332-18, 026216-18, 027795-18	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of London
355 Wellington St, 2nd Floor, Suit 248 LONDON ON N6A 3N7

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

Dearness Home for Senior Citizens
710 Southdale Road East LONDON ON N6E 1R8

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

RHONDA KUKOLY (213), HELENE DESABRAIS (615)

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): October 15, 16, 17, 18, 19, 2018.

Inspector #435 participated in this critical incident inspection.

This inspection was completed concurrently while in the home completing a complaint inspection #2018_605213_0018, log #005873-18 and critical incident inspection #2017_605213_0019, log #027931-18.

This inspection was completed related to the following critical incidents:
Log #005577-17, Critical Incident #M514-000008-17 related to suspected financial abuse.
Log #010956-17, Critical Incident #M514-000018-17 related to alleged resident to resident abuse.
Log #018847-17, Critical Incident #M514-000022-17 related to alleged staff to resident abuse.
Log #024398-17, Critical Incident #M514-000026-17 related to alleged staff to resident abuse.
Log #027261-17, Critical Incident #M514-000041-17 related to alleged resident to resident abuse.
Log #002557-18, Critical Incident #M514-000004-18 related to infection prevention and control and outbreak management.
Log #005799-18, Critical Incident #M514-000005-18 related to infection prevention and control and outbreak management.
Log #006471-18, Critical Incident #M514-000009-18 related to alleged resident to resident abuse.
Log #007992-18, Critical Incident #M514-000022-18 related to a fracture.
Log #008413-18, Critical Incident #M514-000026-18 related to alleged resident to resident abuse.
Log #008524-18, Critical Incident #M514-000022-18 related to alleged staff to resident abuse.
Log #008760-18, Critical Incident #M514-000025-18 related to infection prevention and control and outbreak management.
Log #009037-18, Critical Incident #M514-000028-18 related to infection prevention and control and outbreak management.
Log #009644-18, Critical Incident #M514-000029-18 related to alleged staff to resident abuse.
Log #017371-18, Critical Incident #M514-000031-18 related to falls prevention.

Log #020585-18, Critical Incident #M514-000027-18 related to infection prevention and control and outbreak management.
Log #024332-18, Critical Incident #M514-000038-18 related to infection prevention and control and outbreak management.
Log #026216-18, Critical Incident #M514-000040-18 related to an incident that results in a transfer to hospital.
Log #027795-18, Critical Incident #M514-000043-18 related to infection prevention and control and outbreak management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, three Associate Directors of Care, a Social Worker, the Manager of Accounting and Reporting, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Housekeeping Aide, a Unit/Admissions Clerk, residents and family members.

The Inspectors also made observations and reviewed health records, policies and procedures, internal investigation records, education records and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

Specifically failed to comply with the following:

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 has failed to ensure that an identified resident was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective.

The home reported a critical incident related to an incident that caused injury to an identified resident.

A review of the identified resident's care plan at the time of the incident was noted.

A review of the identified resident's assessments and progress notes surrounding the time of the incident was also reviewed. This review found that upon the first complaint of pain on an identified day by the resident, there were five pain assessments documented and twelve progress notes related which were completed over the course of six days and indicate worsening pain levels ranging from three out of ten to ten out of ten. The resident then required and received intervention on an identified date six days later from the first complaint of pain.

In an interview with a Personal Support Worker (PSW) they indicated it was the expectation that they would report any pain the resident was complaining of to the Registered Practical Nurse (RPN), and also Registered Nurse (RN) if they felt they needed to.

In an interview with an RPN they indicated that it was the expectation to call the physician to assess, and utilize as needed pain medication for any resident complaining or exhibiting signs of pain outside of their normal.

In an interview with the Director of Care (DOC) it was indicated that it was the home's expectation when a resident had a change in their pain, that a pain assessment would be completed. As well as when they were administered as needed pain medications. The DOC stated an increase in pain would indicate a need for physician referral for any pain lasting longer than one day. When asked what the usual routine would include when an identified diagnostic is urgent, the DOC stated it would usually occur the next day.

The licensee has failed to ensure that the identified resident was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective, when the resident complained of pain on an identified day and received intervention six days later. [s. 6. (10) (c)]

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 are reassessed and plans of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, to be implemented voluntarily.

Issued on this 25th day of October, 2018

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

Original report signed by the inspector.