Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775
londondistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: November 14, 2022

Inspection Number: 2022-1543-0001

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Corporation of the County of Elgin

Long Term Care Home and City: Elgin Manor, St Thomas

Lead Inspector	**Inspector Digital Signature**
Melanie Northey (563)	Melanie Northey Digitally signed by Melanie Northey Date: 2022.11.14 15:46:30 -05'00'

Additional Inspector(s)
Cassandra Aleksic (689)
Ina Reynolds (524)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 18, 2022
October 19, 2022
October 20, 2022
October 24, 2022
October 25, 2022
October 26, 2022

The following intake(s) were inspected:

- Intake: #00001562 (Critical Incident) related to resident-to-resident physical aggression
- Intake: #00003684 (Complaint) related to insufficient staffing, medication administration and the fall prevention and management program
- Intake: #00006640 (Follow-up) related to Compliance Order #001 related to the fall prevention and management program
- Intake: #00008606 (Critical Incident) related to the fall prevention and management program
- Intake: #00008853 (Complaint) related to resident abuse and responsive behaviours
- Intake: #00009363 (Critical Incident) related to the fall prevention and management program

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	s. 8 (1) (b)	2022_974670_0007	#001	Melanie Northey (563)

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Medication Management
- Staffing, Training and Care Standards
- Falls Prevention and Management
- Prevention of Abuse and Neglect
- Infection Prevention and Control
- Falls Prevention and Management
- Responsive Behaviours
- Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee shall implement any standard or protocol issued by the Director with respect to infection prevention and control.

IPAC Standard 10.1 stated, “The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90 ABHR.” Public Health Ontario Fact Sheet Titled, Selection and

Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes stated “do not use expired product. Be sure to note product expiration date when selecting product.”

During an initial tour of the home inspectors identified containers of ABHR made available at entrances to resident rooms and common areas that were expired or did not have expiry dates. The ABHR was not observed used by any resident, staff or visitor. The Administrator was informed and all expired products from the resident and common areas were removed.

[689]

Date Remedy Implemented: October 18, 2022

WRITTEN NOTIFICATION: Conditions of Licence

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 101 (4)

Non-compliance with: LTCHA, 2007 s. 101 (4).
The licensee has failed to ensure that they have complied with the conditions to which the licence was subject.

Rationale and Summary
Compliance Order (CO) #001 from inspection 2022_974670_0007 was originally issued on March 28, 2022. The licensee was required to comply with condition B) where "the licensee must ensure that all Registered Nurses and Practical Nurses receive re-training related to the home's policy" and condition C) where "the licensee must keep a record related to the training that indicates the staff members that received the training and the date the training was completed". Inspector #563 reviewed the Surge Learning for the registered staff completion of the "Fall Education for Registered Staff April 2022" and reviewed the registered staff schedules between March 28, 2022, and July 20, 2022. The Manager of Resident Care (MRC) verified a Registered Practical Nurse (RPN) worked July 16 and 17, 2022 and was missed for the education required as part of CO #001 and another RPN worked between March 31-May 3 and did not receive the education required as part of CO #001.

The licensee was required to comply with condition D) where "the Manager of Resident Care or delegate will complete weekly audits of two falls (if available) with a specific focus on falls requiring Head Injury Routine assessments and residents that are experiencing a change in condition or multiple falls", condition E) where the home was to "record and retain the record of any deficits identified in the audits and any corrective actions taken" and condition F) where the "audits are to continue for four months or until compliance is achieved as determined by a follow up inspection." The MRC stated the home created an audit tool titled, "Review of the Post Fall Follow-up Checklist". The audit was dated April 1-May 5, 2022, and there was no other audit presented to Inspectors #563 to support compliance with conditions D), E) and F). The MRC explained the audits were completed by the MRC and the previous Resident Care Coordinator, but the records were no longer accessible.

There was risk of repeating the same non-compliance with the homes Falls Prevention and Management Policy. There was no documented record that the assessments were audited for accurate completion and all registered staff who worked between March 28, 2022 and July 20, 2022 were not provided re-training related to the home's policy.

Sources: Registered Staff Schedule March -July 2022, Surge Learning records, Staff Education Tracking Sheets, April-May Audit, and staff interviews.

[563]

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that a specific pain medication was administered to a resident in accordance with the directions for use specified by the prescriber to administer as needed.

Rationale and Summary
The resident had an order for a specific pain medication as needed. The electronic Medication Administration Record (eMAR) documented the medication was administered to the resident for severe pain and the medication was noted as "I" for ineffective. The medication was administered again with no change in the resident's level of severe pain and the resident stated their pain was unrelieved.

There was no other administration of the specific pain medication administered to the resident when the resident stated the pain medication was ineffective. The Manager of Resident Care verified the specific pain medication was not administered to the resident when their pain scale remained unchanged, and the specific pain medication was to be administered every four hours as needed for severe pain. The resident was at risk for continued severe pain and there was potential for restlessness and increased risk for falls when the resident's severe pain remained unresolved.

Sources: the clinical record for the resident and staff interviews.

[563]

WRITTEN NOTIFICATION: Required Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Non-compliance O. Reg. 246/22, [s. 53 (1) 1]
The licensee has failed to comply with the Falls Prevention and Management Program in the home for the Head Injury Routine (HIR) for three residents.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee was required to ensure the Elgin Manor Falls Prevention and Management Policy last revised March 2022 was complied with as a part of the Falls Prevention and Management Program.

Specifically, staff did not comply with the licensee's Elgin Manor Falls Prevention and Management Policy last which was part of the licensee's Falls Prevention and Management Program.

Rationale and Summary
The Manager of Resident Care (MRC) and Inspector #563 reviewed the neurological records completed for a resident who had fallen. There was a consistent lack of documentation of the resident's pulse, respiration, and temperature monitoring. There were multiple areas of documentation missing from each of the neurological records.

There was an anonymous complaint to the Ministry of Long-Term Care that reported three residents had incomplete documentation on their neurological records from sustained falls. At the time of the inspection the neurological record could not be located for one of the residents and there was missing neurological documentation as part of the HIR for the other two residents. The MRC verified that there was no documented neurological record for one resident and verified the documentation for the other two residents was incomplete.

There was no current neurological record being completed at the time of the inspection for the three residents and progress notes did not identify any negative outcomes due to the lack of neurological monitoring at specific check points.

Sources: Risk Management, clinical records for the residents, and staff interviews.

[563]

WRITTEN NOTIFICATION: Pain Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee 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.

Rationale and Summary
The Pain Management Policy and Procedure last revised March 2022 documented a pain assessment utilizing a clinically appropriate instrument was to be completed when pain was not relieved by initial interventions. Screening for the presence of pain and an indicator for completing a pain assessment was if a resident has pain "i.e. 4 out of 10". To conduct the pain assessment utilizing a clinically appropriate

instrument in Point Click Care (PCC)- Pain Assessment Tool; Pain Assessment in Advanced Dementia (PAINAD) Tool and numerical rating Pain scale. "Registered staff is to ensure the appropriate pain assessment and monitoring tools are selected based on the cognitive ability of each individual resident."

A Registered Practical Nurse (RPN) stated the Pain Assessment was the clinically appropriate assessment used to assess pain on admission, quarterly, annually and with a change, and the pain scale was to monitor the resident's level of pain to determine pain medication administration effectiveness. The RPN verified the pain scale only identified the intensity of the pain and the pain assessment assessed symptoms, causes, location, frequency, type, pharmacological and non-pharmacological interventions, and diagnoses; whereas the pain scale identified the level of pain at the time the resident was asked. The RPN stated the Pain Assessment in Advanced Dementia (PAINAD) was the other clinically appropriate pain assessment in PCC used for residents with dementia.

When the initial intervention to administer a specific pain medication was proven ineffective, there was no Pain Assessment completed to address the ongoing severe pain experienced by the resident. The Manager of Resident Care verified a pain assessment was not completed when it was determined that the resident's severe pain was not relieved by a specific pain medication and the resident's pain scale remained unchanged.

Sources: Pain Assessment Policy, clinical record for the resident and staff interviews.

[563]

WRITTEN NOTIFICATION: Falls Prevention & Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when two residents had fallen, a post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls was completed.

Rationale and Summary
The home's Falls Prevention and Management policy last reviewed March 2022, stated the registered staff are to complete the risk management for falls in Point Click Care, a Pain Assessment, Head to Toe Assessment, and a Post Fall Screen for Resident/Environmental Factors to determine the contributing factors and resulting interventions associated with the fall and to prevent further falls.

A) There was no risk management completed and there was no progress note documentation to describe the nature of the fall for a resident. A Head-to-Toe Assessment, a Post Fall Screen for Resident/Environmental Factors and a Pain Assessment was not completed for the resident when they sustained a fall. The Manager of Resident Care (MRC) verified the assessments were not completed and should have been completed post fall for the resident.

B) A Critical Incident Report documented that a resident had a fall with injury.

The Falls Checklist for the resident was reviewed and stated, "to be completed by registered staff after every fall once the resident has been assessed." There was no documentation, including signature or date on the checklist that the assessments had been completed in Point Click Care.

Review of assessments in Point Click Care showed that the Post Fall Screen for Resident and Environmental Factors was not completed for the resident's fall.

The MRC stated it was the home's expectation that a post fall assessment should have been completed after the fall.

Failure to assess the residents may have increased the risk of harm related to potential unidentified injuries, potential for unresolved pain and a possible delay in obtaining appropriate treatment.

Sources: The home's Falls Prevention and Management Policy; clinical record for the residents, and an interview with the MRC.

[563, 689]