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

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 # / Registre no	Type of Inspection / Genre d'inspection
Dec 30, 2016	2016_520622_0009	016715-16, 020827-16, 026548-16, 030053-16, 031649-16	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE KINGSTON
309 QUEEN MARY ROAD KINGSTON ON K7M 6P4

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

HEATH HEFFERNAN (622)

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): December 2, 5, 6, 7, 8, 9, 14, 15, 2016

This inspection was related to the following critical incidents
Log #020827-16 - injury with transfer to hospital and change of status
Log #031649-19 - injury with transfer to hospital and change of status
Log #016715-16 - alleged resident to resident abuse
Log #030053-16 - alleged staff to resident abuse
Log #026548-16 - alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Physician, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aids (HCA) and residents. The inspector also reviewed residents health records, home policies and procedures, observed resident rooms, the delivery of care, services, staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place which is in compliance with and is implemented in accordance with applicable requirements under the Act is complied with.

As per O.Reg. 79/10 s.48(1) (4) every licensee shall ensure that an interdisciplinary pain management program is developed and implemented to identify pain in residents and manage pain.

According to the critical incident submitted by the nursing home on a specified date, resident #002 had reported concerns to the physician that on an earlier shift, he/she had expressed pain to Registered Practical Nurse (RPN) #110, had requested his/her "pro re nata" (PRN) pain medication as required and did not receive the medication as requested.

During an interview with the inspector, resident #002 indicated that on a specified date he/she had been in pain, asked RPN #110 for his/her PRN pain medication and did not receive it. Resident #002 said he/she reported this incident to the doctor because he/she had been in pain and had not received the medication he/she required. Further interview with resident #002 indicated he/she was in pain throughout the specified shift, he/she reported the pain to the nurse on the next shift who informed resident #002 he/she had not received the PRN pain medication that date and administered the medication as requested. Resident #002 stated he/she required another PRN pain medication at a specified time later that shift to deal with the pain.

Review of the pain management policy reference # RESI-10-03-01 dated March 2014 indicated the homes expectations regarding pain management when a resident is experiencing a new or exacerbation of an existing pain was the pain findings were to be documented in the pain assessment, the progress notes, and/or in the Medication Administration Record note when administering the PRN for pain.

Review of the documentation on the progress notes, pain assessment progress notes and the medication administration records for the specified date indicated that there was no documentation to indicate that a pain assessment for resident #002 had been completed.

The Director of Care (DOC) #102 indicated on the specified date resident #002

complained of pain and had requested pain medication. The DOC further indicated resident #002's pain assessment was not documented.

The licensee failed to ensure that the licensee's pain management policy, reference #RESI-10-03-01 dated March 2014 was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 the licensee's pain management policy, reference #RESI-10-03-01 dated March 2014 is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that pain medications were administered to resident #002 in accordance with the directions for use specified by the prescriber.

According to the Critical Incident submitted by the licensee on a specified date, the physician reported that resident #002 had reported concerns that he/she had expressed pain to RPN #110, requested his/her PRN pain medication and did not receive the medication as requested.

During an interview with the inspector, resident #002 indicated on a specified date, he/she had been in pain, he/she asked RPN #110 for pain medication and did not receive it. Resident #002 indicated he/she reported this incident to the doctor because he/she

was in pain and had not received the medication he/she required.

A review of the Physician's orders on point click care (electronic documentation system) indicated resident #002 had a current order for the requested PRN pain medication.

The Medication Administration Records for resident #002 within the specific month were reviewed and the requested PRN pain medication was not administered on the specified date.

The Progress notes for resident #002 were reviewed for the specified date which indicated there were no progress notes related to complaints of pain or pain medication administration on that date.

During an interview with the inspector, RPN #110 indicated that on a specified date and time, resident #002 had requested his/her PRN pain medication. RPN #110 indicated she assessed resident #002 who indicated he/she had a specified level of pain according to the pain scale. RPN #110 said she returned to her medication cart to get the medication, it was busy, she got distracted which caused her to forget the PRN pain medication. RPN #110 indicated she had not administered the medication as requested by resident #002 for pain.

During an interview with the inspector, the Director of Care (DOC) #102 indicated on a specified date, resident #002 had requested PRN pain medication, indicated his/her pain was at a specified level according to the pain scale, the PRN pain medication was not administered.

The licensee failed to ensure that PRN pain medications were administered to resident #002 on a specified date in accordance with the directions for use specified by the prescriber. [s. 131. (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 to ensure PRN pain medication for resident #002 is administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 30th day of December, 2016

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

Original report signed by the inspector.