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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 5, 2019	2019_618211_0011	009330-19	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare New Orchard Lodge
99 New Orchard Avenue OTTAWA ON K2B 5E6

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

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 8 and 9, 2019.

This inspection was related to a complaint of alleged neglect toward a resident and safe and secure home regarding the main door's lock system.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, a Nurse Practitioner, a Registered Nurse (RN), Support Services Manager, a Registered Practical Nurse (RPN), a Paramedic and a resident.

The inspector also reviewed resident's health care records (including the resident's medication administration records, plan of care, progress notes, assessment for pain) , policies related to Zero Tolerance of Resident Abuse and Neglect and Pain Identification and Management.

The following Inspection Protocols were used during this inspection:
Pain
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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	Légende 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure when resident #001's pain was reassessed and the plan of care reviewed and revised and the care set out in the plan was not effective, the licensee should have ensured that different approaches were considered in the revision of the plan of care.

On an identified date, the Ministry of Health and Long-Term Care (MOHLTH) received a complaint that the emergency services (911) was called twice by resident #001 complaining of a specific medical condition on an identified date. When the resident was assessed by the paramedics, the resident was in the specific medical condition with other health issues and was sent to the hospital.

A review of resident #001's plan of care for an identified date indicated the resident suffered from two specifics health conditions. The plan of care indicated to spend time talking with the resident to encourage the resident to express their feeling, their anxiety and worries related to the health issues. The resident's plan of care also indicated to provide reassurance as needed.

A review of the resident's physician order on a specific date, prescribed to stop an identified pain medication at an identified time once a day and instead to divide the dose of the above identified medication and administered at two different times daily.

The resident's Medication Administration Medication (MAR) revealed that the resident received an identified pain medication on a specific date during the evening shift. Resident #001's MAR indicated that RN #102 administered another type of medication for breakthrough pain and another identified medication for a different health condition later during that same shift. Then, another medication was administered for a different health condition eight minutes after the first two medications were administered. During the same shift, a fourth medication was given twenty-nine minutes later for another health condition.

A review of the resident's MAR indicated to administer a specific pain medication as first line treatment of breakthrough pain and if no improvement, give another kind of pain medication every four hours as needed. The MAR revealed that the resident was not administered the other kind of medication for breakthrough pain during that identified shift.

A review of the resident's progress notes on an identified date, indicated that the resident asked for more pain medication. The resident was told that PRN pain medication and other type of medications were just given and to wait for the medication to be effective. Later during the identified shift, the RN #102 wrote that the resident returned to the nursing station, and demonstrated specific behaviours and stated having an identified pain. By the time an identified instrument was brought to the resident, the paramedics had arrived.

In an interview with resident #001 on an identified date, the resident stated suffering from two kinds of specific pains during the identified shifts. The resident stated that RN #102 administered a specific medication for pain, but the medication was not effective. The resident stated calling 911 and the call was cancelled by RN #102. The resident stated a second call was made to the emergency services (911) since the pain from the two different body areas were excoriating.

In an interview with the Nurse Practitioner on an identified date, revealed that the resident becomes very anxious when the resident experienced pain. The resident needs reassurance of 1:1 person until the pain will be controlled.

In an interview with RN #102 on an identified date, the RN stated that resident #001 has a history of chronic pain and multiple pain's medications was ordered. RN #102 revealed that the resident received pain medication at the beginning of the identified shift and the resident returned soon afterwards stating that the pain was still present. The resident was told "You just had the medication. Wait a bit". RN #102 explained trying to persuade the resident to wait a little bit longer to evaluate if the pain medication will become effective. RN #102 stated that the pain level was documented in the resident's electronic chart under the assessment section when the resident received a pain medication.

In an interview with the DOC on an identified date, stated that when a nurse gives a pain medication prescribed as PRN (when necessary), the nurse needs to document the resident's level of pain and the location of the pain in the computer under the section titled "Pain Management Assessment". However, the DOC confirmed that the pain medication was not documented when the PRN medication was given nor when the pain was reassessed by RN #102. The DOC stated when resident #001 became anxious and told RN #102 that the pain was not controlled, the RN should have stayed 1:1 with resident #001 to give reassurance. The DOC confirmed that RN #102 should have considered different approaches to reassess resident #001's pain and to decrease the resident's anxiety. [s. 6. (11) (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 when resident #001's pain was reassessed and the plan of care reviewed and revised and the care set out in the plan has not been effective, the licensee shall ensure that different approached are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 resident #001's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #001's MAR for an identified month, indicated that RN #102 administered medications for breakthrough pain on an identified shift and later, the resident received another type of medication.

A review of the home's policy #RC-19-01-01 "Pain Identification and Management" dated February 2017, indicate to assess residents for pain using the Pain Flow Note in the electronic documentation in the Point Click Care (PCC). A pain flow note will be used to record pre and post intervention/analgesia administration.

In an interview with the DOC on an identified date, stated that RN #102 did not documented the pre and post pain assessment in the resident's progress notes during the identified shifts. The DOC confirmed that RN #102 did not used the clinically appropriate assessment instrument specifically designed to assess resident's pain when the resident was administered the pain medications on two different times during that shift. [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 to ensure when resident #001'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.

Issued on this 6th day of June, 2019

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

Original report signed by the inspector.