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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2017	2017_686600_0016	031828-16	Complaint

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

GEORGIAN MANOR HOME FOR THE AGED
7 HARRIET STREET PENETANGUISHENE ON L9M 1K8

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

GORDANA KRSTEVSKA (600)

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): September 19, 20, 21, 22, 25, 26, 27, 28, and 29, 2017.

During this inspection Complaint #031828-16, was inspected regarding Falls Prevention, Pain Management, Continence Care and Bowel Management, and Sufficient Staffing.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, acting Director of Care (ADOC), acting Nurse Manager (NM), Registered Dietitian (RD), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW), Resident Assessment Instrument (RAI) - Coordinator, Health Care Aid (HCA) Substitute Decision Maker (SDM), housekeeping staff, and residents.

During the course of the inspection, the inspectors observed the provision of care, staff-resident interaction, reviewed clinical records, staff education records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Pain
Sufficient Staffing

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

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 that the care set out in the plan of care was provided to resident #001 as specified in the plan.

An identified complaint was submitted to the Ministry Of Health and Long Term Care (MOHLTC) on an identified date with concern regarding incident prevention strategies in place for resident #001 from January to March 2016. Resident #001 was admitted in the home on a specified date and was discharged three years later.

Review of resident #001's incidents assessment records revealed that the resident had been assessed for risk of incidents on admission and each quarter after admission. The assessments indicated resident #001 had been identified to be at high risk for incidents and the most recent assessment prior the first incident in the identified period, indicated resident #001 was identified to be at high risk for incidents due to history of incidents, use of identified drugs, medical condition and due to change in the treatments. Further the record indicated resident #001 had change in behaviour daily, seven days prior the assessment, change in health condition and change in the gait pattern.

Review of the post fall assessment records for the period identified by the complainant indicated that resident #001 had one near miss incident in a common area and three incidents in resident's room and hallway.

A review of resident #001's written plan of care revealed that the resident was unsteady on feet and needed extensive assistance by one staff through entire process of ADLs to ensure safety to the resident. He/she was to be assisted with one of the ADLs every two

hours (Q2H) while awake, first thing in the morning, before and after meals, at bed time (HS) and as needed (PRN).

Interview with PSW #145 revealed that he/she would assist resident #001, with the identified ADL usually only twice per shift and assumed other staff would have assisted the resident when he/she was not around. Further the PSW confirmed that he/she assisted the resident in the morning of the identified date but did not have a time to go back to assist him/her again. He/she confirmed that he/she did not assist the resident in March on the identified date either before or after lunch, as directed by the plan of care. PSW #145 indicated that on this day the resident had incident in his/her bathroom. Post fall assessment record review indicated the resident had an incident after lunch.

Review of a Personal Support Worker (PSW)'s daily documentation survey report for two identified dates indicated both days resident #001 was assisted with a specified ADL only once per shift.

Interview with PSW #149 revealed that when he/she did rounds at the beginning of the shift, on the second identified date, he/she found resident #001 in his/her room after the incident with change in a condition, blocking the room door with his/her body. The PSW confirmed that he\she did not assisted the resident prior to the incident.

Registered staff who had attended to the resident at the time of the falls in March 2016, was no longer an employee of the home.

Interview with Health Care Aid (HCA) #147, who also provided care to resident #001 confirmed that he/she would only assist the resident with the identified ADL twice per shift and not every two hours as indicated in resident's plan of care.

Interview with ANM #138 revealed the staff was to assist the resident with the identified ADL as indicated in the plan of care in order to provide safety to the resident as resident #001 was high risk for incidents. The ANM further confirmed that the staff did not follow resident #001's written plan of care for both incidents in March, 2016.

Interview with ADOC confirmed the staff are expected to provide care to the residents as specified in the plan of care. [s. 6. (7)]

2. An identified complaint was submitted to the MOHLTC on a specified date with concern regarding resident #001's health condition management. The complainant

indicated that the resident had not received any treatments at times when the resident had expressed signs of discomfort.

Review of resident #001's written plan of care revealed the resident was identified to have a chronic discomfort in some identified body areas on admission. Interventions initially planned to relieve the resident's discomfort was staff were to complete an identified assessment quarterly and with any change of condition, administer treatment as per MD orders and note the effect of the treatment.

Review of resident #001's clinical record revealed that the resident was ordered medical directive on an identified date in 2014 for an identified treatment to be given one to two by mouth (PO), every four hours (q4h) as needed (PRN) for identified health condition.

Review of resident #001's minimum data set (MDS) assessment record on a specified date in 2015, revealed that resident #001 had cognitive impairment. Further the record review revealed that the resident was observed to have indicators of discomfort five days a week within the 30 days prior the assessment. Review of a quarterly Assessment: Non Cognitive Resident record conducted on an identified date in 2015, by Registered Nurse (RN) #133 revealed that resident #001 had indication of discomfort. A review of the home policy #NPC E-15, revised September 2016, recognized the above mentioned resident's condition indicative of discomfort.

Review of resident #001's medication administration record (MAR) for December 2015, revealed no treatment was administered to the resident for the identified symptoms of discomfort the resident had been prescribed during the 30 days observation period. Last documentation signed as administered treatment was dated two days in November 2015, as the resident had been experiencing discomfort.

Interview with SDM revealed he/she had been requesting from the staff to provide treatment every four hours as per order, as the resident was showing signs of discomfort but not able to verbalize his/herself. Further the SDM stated the staff would start the treatment for day or two, then will stop explaining to the SDM that the resident did not complain of discomfort.

Interview with RNNM #138 revealed that when staff assess a cognitively impaired resident for discomfort, staff are to look for signs and symptoms of discomfort that include the identified changes in a condition. The RNNM confirmed that the staff should have considered the resident non-verbal and behaviour as indication of discomfort and

administer the PRN treatment as ordered.

Interview with ADOC confirmed the staff are expected to monitor residents who are cognitively impaired for signs of discomfort and follow up with the PRN treatment. [s. 6. (7)]

3. The licensee has failed to ensure that when the resident is reassessed and the plan of care reviewed and revised because care set out in the plan had not been effective, different approaches are considered in the revision of the plan of care.

An identified complaint had been submitted to the MOHLTC on an identified date regarding concern in area of an identified change in a health condition.

Review of resident #001's plan of care indicated a pattern of the identified change and he/she was on medical directive to manage the change. Review of resident #001's MAR revealed the resident's intervention for managing the identified changes.

Review of the resident's Daily PSW documentation record for December, 2015, indicated resident #001's health condition had changed.

Review of the resident's MAR revealed that the resident had been receiving the interventions for managing changes in health condition as ordered.

Review of Resident Assessment Protocol (RAP) for month of December 2015, revealed the resident had been triggered for change in health condition, however the team decided that the plan of care was effective. There was no indication that the plan of care had been revised or considered different approaches.

Review of resident #001's progress notes between January and March, 2017, revealed on a specified date in 2016, resident had been transferred for further assessment due to increased discomfort. An assessment conducted in the hospital revealed a change in a health condition and a specified treatment had been given twice without results. The resident had been sent home with recommendation to repeat the treatment if no result from the initial treatment. The follow up assessment indicated that there was still a change in the resident's health condition. A further assessment conducted the next months indicated the resident's health condition had not restored. RAP dated March 2016, indicated again that the resident was triggered for the change in the health condition and the RN acknowledged that this was an ongoing issue.

Review of the resident's MDS record for March, 2016, revealed resident #001 was identified to be at risk of change in health condition. Review of the resident assessment protocol indicated that the staff was aware that resident #001 had routine treatment for managing the changes in the condition and ongoing issues with it but would not refer resident #001 for further assessment or treatment. Further review of resident #001's plan of care failed to reveal nutrition and hydration protocol to be included in prevention of the identified changes. Review of the resident's written plan of care under the identified problems failed to reveal any focus, goal or intervention for managing that function.

Interview with the Registered Dietitian confirmed resident #001 had not been referred for treatment of the identified change in condition and nutrition and hydration were not included in the protocol as resident #001's plan of care indicated.

Interview with RNNM #138 and the ADOC confirmed that resident #001 had not been reassessed and care plan reviewed and revised when the care set out in the plan had not been effective. [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 that the care set out in the plan of care was provided to the resident as specified in the plan, 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 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.

An identified complaint was submitted to the MOHLTC on an identified date with concern that resident #001's change in the health condition had not been managed well.

Review of resident #001's MDS assessment record from an identified date in 2015, revealed that resident #001 had cognitive impairment. Further the record review revealed that the resident was observed to have indicators of discomfort five days a week within the 30 days prior the assessment.

Review of resident #001's MAR for two identified months of 2015, indicated the resident had received PRN treatment on two identified occasion in one month as the resident had been experiencing discomfort. Further review of the MAR for the following months indicated that resident #001 had received the PRN treatment but was not effective so on an identified date, a month after the previous treatment, the resident was ordered change of the treatment, every four hours (q4h) PRN. Review of the resident's MAR further indicated that resident #001 had received the PRN treatment 23 days within the two months.

Review of the assessment record: non cognitive resident tool record indicated the resident was not assessed for a discomfort from December 2015, until March 2016. Progress note from an identified date for Non Triggered Rap, indicated that resident had exhibited some non-verbal signs of discomfort after PRN treatment was administered so a new treatment had been ordered in March 2016.

Interview with RNNM #138 confirmed that the resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose after the resident had receive treatment on as needed basis and was not effective as resident #001 still experienced signs of discomfort.

Interview with DOC confirmed the registered staff is expected to complete the assessment tool for non cognitive resident on admission, quarterly and when resident's condition change. Also the staff is expected to assess the resident each time when PRN treatments are administered using the clinically appropriate assessment instrument specifically designed for this purpose. [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 that when the resident's pain was 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 8th day of November, 2017

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

Original report signed by the inspector.