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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 15, 2014	2014_199161_0017	O-000711-14	Resident Quality Inspection

Licensee/Titulaire de permis

HILLTOP MANOR NURSING HOME LIMITED
82 Colonel By Crescent, Smiths Falls, ON, K7A-5B6

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

HILLTOP MANOR NURSING HOME LIMITED
1005 ST LAWRENCE STREET, P.O. BOX 430, MERRICKVILLE, ON, K0G-1N0

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

KATHLEEN SMID (161), AMANDA NIXON (148), HUMPHREY JACQUES (599), RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 29, 30, 31, August1, 5, 6, 7, 8, 2014.

During the course of the inspection,the inspector(s) conducted a complaint investigation log #O-000758-14.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, the home's Administrator, Director of Care (DOC), Associate Director of Care (ADOC) Resident Assessment (RAI)Coordinator, Director of Environmental Services (DES), Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Housekeepers.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents’ health care records, home policies related to access to health care records, medication management system, infection control and prevention, and prevention of abuse and neglect of Residents, staff work routines, posted menus, reviewed Residents' Council minutes. The inspector(s) also observed Resident rooms, Resident common areas, observed two medication passes, several meal services, and the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 :

The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6(1)(a), whereby the licensee did not ensure that the written plan of care for each resident sets out the planned care for the resident.

The plan of care for assistive aids for Resident #12 indicates that the resident requires the application of a right side table tray to provide support and rest for the resident's arm. In addition, the plan of care indicates the use of a seat belt when up in his/her wheelchair for resident safety and that the resident is able to "undo" the seat belt.

On August 1, 2014, Inspector #148 spoke with the ADOC related to the resident's use

of a right side table tray. The ADOC confirmed that the resident does not use a right side table tray but rather is to have a full table tray applied when the resident is in his/her wheelchair.

On August 1, 2014, Inspector #148 spoke with PSW Staff #111, who is responsible for the resident's care, who indicated that Resident #12 was not able to remove the seat belt. Observations of the Resident in the presence of the ADOC, confirmed the resident was not able to remove the seat belt.

The written plan of care for Resident #12 does not set out the planned care for the resident, specifically as it relates to the use of a table tray and the resident's ability to remove his/her seat belt.

On August 1, 2014, Resident #7 was observed by Inspector #148 to have a chair alarm applied while up in his/her wheelchair. On August 5, 2014, the Inspector observed the resident in his/her wheelchair without the clip of the chair alarm attached to the resident, rather the clip and cord were hanging and wrapped around the wheel of the chair. PSW Staff #S117 who was responsible for the resident's care on August 5, 2014, indicated that the clip and cord have been wrapped around the chair since the start of her day shift. Both Staff #S117 and Registered Nurse Staff #S100, confirmed that the resident is to have the chair alarm applied when up in his/her wheelchair due to the risk of falls. On August 6, 2014, Inspector #148 confirmed that the clip and cord of the chair alarm are available for use.

The plan of care for Resident #7 was reviewed and indicates the use of a TAB monitor when the resident is in bed and while sitting in the bedside chair. There is no indication of the use of a TAB monitor or other chair alarm while in wheelchair.

The written plan of care for Resident #7 does not set out the planned care for the resident, specifically as it relates to the use of a chair alarm while in his/her wheelchair.

Resident #14's most recent plan of care was provided to Inspector #161 by the Director of Care. It indicates that Resident #14 is occasionally incontinent of urine and is toileted in the morning, before and after meals, bedtime and as required (page 2/12). The plan of care also indicates that Resident #14 is toileted at 7:00 a.m., 10:00 a.m., 12:00 a.m., 2:00 p.m., 5:00 p.m., 8:00 p.m., at bedtime and as needed. The care

plan also indicates that the Resident is bedridden (page 5/12).

On August 7, 2014, Inspector #161 spoke with the ADOC related to the discrepancies in Resident #14's most recent plan of care. The ADOC confirmed that given the medical condition of Resident #14, the Resident is bedridden, receiving palliative care and is offered a bedpan rather than being toileted. This was also confirmed by PSW #S111, PSW #S121 and RN #100.

The written plan of care for Resident #14 does not set out the planned care for the resident, specifically as it relates to bladder incontinence and toileting.[Log # O-000758-14] [s. 6. (1) (a)]

Resident #5 experiences visual hallucinations and becomes agitated and verbally aggressive as documented in the resident's progress notes.

On a specified date in August 2014 - Nursing Progress Note: "the Resident was extremely agitated and argumentative with staff this afternoon. Requesting for us to take him/her down the street to see his/ her granddaughter. The Resident was yelling and causing a scene in the hallways. Allowed the Resident to call his/her daughter Ann. She left a message calling the staff a rude name". His/Her son eventually came in. The Resident has settled as of dinner time".

On a specified date in July 2014 - Nursing Progress Note: "The Resident stated to writer that there was a corpse in his/her bed this afternoon. Went into the Resident's room with him/her and attempted to reassure the Resident that there was nothing in the bed. Did not seem to assured".

On a specified date in May 2014- Nursing Progress Note: "The Resident was very paranoid and wanting to change his/her bed with his/her room mate. The Resident was fearful of someone coming in the window".

On Aug. 6, 2014 during an interview PSW #S109 who provides direct care to the Resident #5 stated that Resident #5 experiences visual hallucinations usually first thing in the morning when they are getting up and late at night. PSW #S109 stated staff will distract the resident by talking about something else or call a family member to come in and visit with the resident if staff cannot settle the resident.

Aug. 6, 2014 during an interview the ADOC #S103 confirmed the interventions for

Resident #5 related to the Resident's visual hallucinations is to distract the Resident by either changing the subject or bringing the Resident to the nursing station to sit with staff until the Resident is settled. If this intervention is not successful the staff will call a family member, either Resident #5's daughter or son who will come into the home and settle the resident.

The written plan of care does not set out the planned care for Resident #5 related to the Resident's visual hallucinations. [s. 6. (1) (a)]

The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (7), whereby the licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The plan of care for Resident #12 indicates that a basic seat belt will be used when resident is up in his/her wheelchair for safety and to prevent the risk of falls.

Resident #12 was observed by Inspector #148 on the morning of July 29, 2014 to be seated in a wheelchair in the activity space with no seat belt applied. On the morning of July 30, 2014, the resident was observed to be seated in a wheelchair in the activity space with a seat belt applied. On the morning of August 1, 2014, the resident was observed seated in a wheelchair in the activity space with no seat belt applied. The Inspector requested assistance and PSW Staff #S115 repositioned the resident and applied the seat belt indicating that the resident is to have the lap belt applied when seated in his/her wheelchair.

The plan of care related to the application of physical devices, specifically a seat belt, were not provided as set out in the plan of care for Resident #12.

The licensee failed comply with LTCHA 2007, S.O. 2007, c.8, s.6(8), whereby the licensee did not ensure that the staff and other who provided direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The plan of care for Resident #12 indicates that a basic seat belt will be used when resident is up in his/her wheelchair for safety and to prevent the risk of falls. In addition, the plan of care indicates that a side table is used on the right side of the

resident's wheelchair to support the resident's right arm.

On the morning of August 1, 2014, Inspector #148 observed Resident #12 to be seated in a wheelchair without either the seat belt or table tray applied. PSW Staff #S109, had completed morning care for Resident #12 and had transferred the resident to his/her wheelchair. Staff #S109 indicated that she was not aware that the resident required any physical devices.

Staff #109, who provided direct care to Resident #12 was not aware of the contents of the plan of care.

On July 31, 2014 Inspector #549 interviewed the ADOC who indicated that the Personal Support Workers provide care to residents following the resident's individualized Kardex which is accessed using the Point of Care software program. The ADOC indicated that the PSWs do not have access to residents plan of care and as such, the care provided to the resident's is inconsistent.

Comparing the most current written Plans of Care and the Kardex in the Point of Care software program for the following residents, there were discrepancies noted as detailed below.

Resident #17 written plan of care related to urinary incontinence indicated the resident is able to voice his/her toileting needs and that staff are to evaluate resident #17's bowel control patterns and to increase fluids.

These interventions were not in the Kardex for the direct care staff to provide care.

Resident# 4 the written plan of care related to eating indicated the resident is to be provided with a modified diabetic diet; toileting interventions included to provide encouragement and one staff for limited assist; dressing interventions include staff to pick out a couple of appropriate outfits and offer choices; risk of fall interventions include staff to ensure that the resident's call bell is pinned to the resident's gown when in bed and to ensure the environment is free of clutter.

These interventions for resident #4 were not in the Kardex for the direct care staff to provide care.

Resident #18 written plan of care related to mobility interventions staff are to observe

ambulation for endurance and steadiness; dressing interventions for staff include offering the resident two choices of clothing.

These interventions for resident #18 were not in the Kardex for the direct care staff to provide care.

The Kardex for residents #17, #4, #18 does not reflect their current plans of care set out in the residents written plan of care. PSW's do not have access to the residents written plan of care. [s. 6. (8)]

The licensee had failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(10)(c) in that the licensee did not ensure that Resident #14 was reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective.

Resident #14 has an extensive leg wound involving the left lower leg and heel. On a specified date in July 2014 the Resident was assessed by a vascular surgeon regarding treatment of his/her leg wound. The surgeon concluded that a possible amputation of Resident #14's left lower leg might be necessary for pain control. The South East Palliative Pain and Symptom Management Consultation service has been following Resident #14 for pain management. On the most recent RAI-MDS 2.0 assessment Resident #14 scored 3 out 3 on the Pain Scale, indicating daily horrible or excruciating pain.

Resident #14's pain is assessed using the Pain Assessment in Advanced Dementia scale (PAINAD) that had been recommended by the South East Palliative Pain and Symptom Management Consultant. On August 5, 2014 Inspector #161 asked for and received from the Director of Care, copies of Resident #14's PAINADs completed for June, July and August 1 – 5, 2014. These were subsequently reviewed by Inspector #161 and the results are detailed below.

From June 6 to August 5, 2014 the PAINAD tool was used 65 times to assess Resident #14's pain. The results indicated that Resident #14 was experiencing moderate to severe pain 54/65 times. A review of Resident #14's health care record including physician's orders, physician notes, medication administration record, progress notes and care plan for June 2014 indicated that there had been no changes in the Resident's plan of care related to effective pain management strategies.

On August 5, 2014 at approximately 10:20 a.m. Inspector #161 and # 549 observed Resident #14 lying in bed with facial grimacing and moaning loudly. Inspector #549 asked the Resident if he/she was alright. Resident #14 stated that he/she was having "terrible pain in his/her left leg below the knee." The Resident's lower legs had been uncovered by RPN #S105 and a PSW in preparation for an imminent dressing change to his/her left lower leg. When the PSW lifted Resident #14's right leg to move it slightly so as to provide better access to the Resident's left lower leg, Resident #14 cried out in pain. Inspector #161 interrupted RPN #S105's ongoing preparation for Resident #14's dressing change when she asked RPN #S105 if the Resident had received any pain medication in anticipation of this dressing change. RPN #S105 indicated to Inspectors #161 and #549 that she had administered Hydromorphone to Resident #14 approximately one hour ago. She then stated to the Inspectors that she would check to see if Resident #14 could be given more analgesia which she would administer, then wait for the analgesia to be effective and change the Resident's dressing.

A review of Resident #14's Medication Administration Record indicated that on August 5, 2014 the Resident had received Hydromorphone 0.5 mg at 8:20 a.m. which was two hours prior to the dressing change planned for 10:20 on August 5, 2014.

On August 5, 2014 at 10:27, Inspector #161 discussed the observations made with regard to ineffective pain management for Resident #14's dressing change with the Associate Director of Care. She immediately facilitated changes in Resident #14's plan of care related to pain management which included the following:

On August 5, 2014 at 10:30, the attending physician was notified by telephone and ordered a short acting benzodiazepine to be administered 15 minutes prior to Resident #14's left leg dressing changes.

On August 6, 2014 morning, the Palliative Pain and Symptom Management Consultant assessed Resident #14 and provided recommendations to the health care team at the home which included the need for a more aggressive approach to pain management. The attending physician who was in the home at the time agreed to further changes in medications.

Resident #14's pain was not reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

The licensee has a history of non-compliance with LTCHA 2007 S.O. 2007, c.8, s.6(10)(b) related to pain management. A Compliance Order was issued on August 13, 2012 as a result of inspection #2012-039126-0001

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 is provided to Resident #12 related to the application of a restraint, 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 :

The licensee has failed to comply with O.Reg 79/10 r. 131(2) in that the licensee did not ensure that drugs are administered to Resident #14 in accordance with the directions for use specified by the prescriber.

Resident #14 has an extensive leg wound involving the Resident's left lower leg and heel. On a specified date in July 12014 the Resident was assessed by a vascular surgeon regarding treatment of the leg wound. The surgeon concluded that that a possible amputation of Resident #14's left lower leg might be necessary for pain control. The South East Palliative Pain and Symptom Management Consultation service has been following Resident #14 for pain management. On the most recent RAI-MDS 2.0 assessment (July 8, 2014), Resident #14 scored 3 out 3 on the Pain Scale, indicating daily horrible or excruciating pain.

The Physician's Orders dated June 6, 2014 state that Resident #14 is to receive Hydromorphone 1 mg by mouth every 4 hours around the clock. If the Resident is unable to swallow the Hydromorphone by mouth, Resident #14 is to receive this medication subcutaneously every 4 hours around the clock. The Hydromorphone 1 mg is to be administered to Resident #14 at midnight, 4:00 a.m., 8:00 a.m., noon, 4:00 p.m., and 8:00 p.m.

Resident #14's Medication Administration Records for the months of June, July, and August 1 -5, 2014 were reviewed by Inspector #161 and the home's ADOC. From June 1 – August 5, 2014, Resident #14 was not administered her scheduled Hydromorphone 1 mg on 13 occasions.

A review of the home's "Medications not Administered" document which Registered Staff use for documenting reasons for not administering medications was reviewed for June, July, and August 1 – 5, 2014. All entries in this document indicated that Resident #14 was not administered Hydromorphone 1 mg every four hours around the clock because the Resident was sleeping. This was verified by the ADOC.

On August 7, 2014 the ADOC indicated to Inspector #161 that upon recommendation by the South East Palliative Pain and Symptom Management Consultant, the home uses the Pain Assessment in Advanced Dementia Scale (PAINAD) tool to assess Resident 14's pain.

Hence, the dates in June, July, August 1 -5, 2014 when Resident #14 did not receive his/her scheduled Hydromorphone, were compared to the PAINAD assessments conducted on/near those dates. On the 13 occasions that Resident #14 did not receive his/her scheduled Hydromorphone, all PAINAD Summary scores indicated that the Resident was experiencing moderate to severe pain.

Resident #14 was not administered Hydormorphone 1 mg every 4 hours around the clock in June, July and August 1 – 5, 2014 in accordance with the directions for use specified by the prescriber. [log # O-000758-14]

The licensee has a history of non-compliance with O.Reg 79/10 r. 131(2) A Voluntary Plan of Corrective Action (VPC) was issued on August 4, 2012 as a result of inspection #2012-039126-0001. [s. 131. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.8(1)(b), whereby the licensee did not ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents.

A review of the resident care assignment for the home's personal support workers indicates that the day routine for "PSW #3" includes the following as the Dining Room Assignment: two identified tables, serve cereal/soup to entire dining room, assist/feed at assigned tables, serve meal to entire dining room, complete documentation for entire dining room, stay in dining room until all residents have left.

Inspector #148 observed the lunch meal service on July 29 and August 1, 2014.

On August 1, 2014 the inspector observed the two identified tables assigned to "PSW #3", to be the responsibility of PSW Staff #S109. Staff #S109 confirmed that she was to provide all meal service activities including serving, clearing of dirty dishes and feeding assistance to both tables #5 and #6 as well as a responsibility to serve other tables as needed. Eight residents reside between the two identified tables. The health care record for each resident is described below as it relates to the resident's need for feeding assistance:

Table #5

Resident #1 – total assistance
Resident #2 – limited to extensive assistance
Resident #20 – eats independently with finger foods, requires extensive to total feeding assistance if the meal requires cutlery
Resident #21 – independent

Table #6
Resident #19 – total assistance
Resident #22 – extensive assistance
Resident #23 – extensive assistance
Resident #24 – extensive assistance

On August 1, 2014, Staff #S109 provided soup to both identified tables at approximately 12:09pm. The staff member then proceeded to provide feeding assistance to Resident #19. However, Staff S#109 provided intermittent physical assist to resident #19 as the staff member continued to leave this resident table to provide meal service activities to the second table and residents #2, #20 and #21. Resident #19 would be provided a spoonful of soup, and then Staff #S109 would leave the table to return minutes later to provide another spoonful of soup. At 12:25pm with less that 50% of the soup taken by Resident #19, Staff #S109 removed the clothing protector of the resident and reported that the resident had fallen asleep and that to prevent choking the resident will not be provided any further meal service. Resident #19 was then offered milk, which was not taken by the resident. At 12:36pm the resident was removed from the dining room without further attempts to wake or offer of the main meal. During this time, tablemates Resident #22 and #23 were observed to be having difficulty feeding themselves the meal with less than 50% eaten and fluids untouched. Staff #S109 was observed to provided verbal encouragement intermittently through the meal. At 12:34pm, Staff #S109 provided physical assist to both residents. Assistance with fluids, however, was not provided and Resident #22 took only sips of juice. Resident #23 was observed to take fluid on his/her own, once cups/glasses were put within reach by Staff #S109. Both residents were able to consume the dessert, a finger food, on their own. Staff #S109 reported to the Inspector that there are three residents requiring feeding assistance at this table, including Residents #19, #22 and #23. Staff #109 acknowledged that there were also residents, including Resident #1, who required feeding assistance at the second table that she had not yet been able to assist.

Resident #1, who was provided soup at 12:09pm, was provided a plate of the main

meal at 12:19pm, between 12:09pm and 12:36pm no feeding assistance was provided. At 12:37pm Staff #S109 requested the soup and meal be reheated, at 12:39pm Staff #S109 provided the resident with feeding assistance of the soup. At 12:41pm, Staff #S109 left the table of Resident #1 to provide desserts to another table, intermittent physical assistance was provided to Resident #1 between 12:41pm and 12:53pm, as the staff member was providing service to table #6 as well as Resident #2 and #20. Resident #1 consumed only 50% of the soup and only bits of the main meal, only sips of fluid taken.

Resident #2, who was provided soup at 12:09pm, was observed to pick at the soup bowl but did not attempt to feed self until a staff member provided verbal encouragement and place the spoon in the resident's hand at 12:35pm, prior to 12:35pm, no staff member provided encouragement or assistance.

On July 29, 2014, Inspector #148 observed the two identified tables assigned to "PSW #3", whereby PSW Staff #S102 was responsible for the serving, clearing and feeding assistance for both tables. Similar observations were made in which intermittent physical assistance was provided to Resident #1 and #19 along with delay of resident feeding assistance after soup and/or meal was provided to Resident #1 and #19.

As a result of the organization of personal support service, Resident #1 and #19 who both require total feeding assistance, were provided with intermittent physical assist, both with less than 25% of food and fluids consumed at the end of their meal service on August 1, 2014. Also, Resident #1 was seated with his/her soup without any assistance for approximately 20 minutes and Resident #2 was seated with his/her soup without any assistance for approximately 25 minutes on the same date. In addition, assistance was delayed for Resident #22 and #23, both of whom required physical assistance with the use of cutlery.

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 home has an organized program of personal support service to meet the assessed needs of residents, specifically as it relates to the provision of meal service and feeding assistance, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s.9 (1)(iii), whereby the licensee did not ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including

balconies and terraces, or doors that residents do not have access to, must be equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

There are six doors leading to the outside of the home that are accessible to residents. The six doors are described as follows:
1- West Door, located at the end of the west resident hallway
2- North Door, located at the end of the north resident hallway
3- East outside door, located within a vestibule beyond an unlocked door accessible to residents
4- South outside door, located within a vestibule beyond an unlocked door accessible to residents
5- Patio Door, located within the resident activity/lounge area
6- Front Door, located at the front of the home

There are two doors leading to stairways that are accessible to residents, described as follows:
1- East Stairway, located within a vestibule beyond an unlocked door accessible to residents
2- South Stairway, located within a vestibule beyond an unlocked door accessible to residents

On July 31, 2014, in the company of the Director of Environment Services (DES), Inspector #148 reviewed the alarm system for each of the above doors. It was confirmed that the door alarm system is separate from the resident-staff communication system and that all of the doors leading to the outside of the home and stairways are connected to the audio visual enunciator at the home's one nursing station. It was noted that two of the doors, East outside door and the North Door, did not have a visual indicator illuminate at the enunciator. The DES suspected this was due to the bulbs having been burnt out.

During the review it was confirmed that the West Door, North Door, East outside door, South outside door and Patio Doors are not equipped with an audible door alarm that allows calls to be cancelled only at the point of activation. [s. 9. (1)]

2. The licensee failed to comply with O.Reg 79/10 s.9(1)2., whereby the licensee did not ensure that all doors leading to non-residential areas must be equipped with locks

to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the initial tour of the home, on July 29, 2014, Inspector #148 identified four doors leading to non-residential areas that were not equipped with locks to restrict unsupervised access to those areas by residents.

The East and South Door each lead to a small vestibule. Within each vestibule was a door leading to the outside of the home and a door leading to a stairway. In the company of the home's DES it was confirmed that the vestibules are accessible to residents, as the doors are not equipped with locks and that the areas were considered non-residential areas.

The home has an administration area near the South end of the building. To access the offices of the administration area, a person must first pass through a door from the hallway that leads to a corridor that includes two unlocked bathrooms and a locked Janitor closet. At the end of this corridor is a door equipped with a lock that is the entrance point to the administration offices. On the morning of July 30, 2014, Inspector #549 observed that the entrance door to the administration offices was locked and the corridor was unsupervised. On the morning of July 30, 2014, Inspector #148 observed the entrance door to the administration offices unlocked and no staff present at the time, leaving the corridor unsupervised. On July 30, 2014 in the company of the DES, the door leading from the hallway to the corridor was confirmed to not be equipped with a lock and the area was considered to be a non-residential area. The DES indicated the bathrooms in the corridor are used by staff and family/visitors and for this reason the door leading from the hallway to the corridor, has never been equipped with a lock.

The home has an Oxygen Storage area, located near the nursing station in which the door is not equipped with a lock. Within the area is several oxygen tanks and related equipment. There is space enough for an ambulatory resident to enter the area and close the door.

During the inspection, several doors were identified that lead to non-residential areas, in which the doors were not equipped with locks. [s. 9. (1) 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 doors leading to stairways and the outside of the home are equipped with an audible door alarm and that doors leading to non-residential areas must be equipped with locks to restrict unsupervised access, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg s.17(1)(e), whereby the licensee did not ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

During observations of July 29, 2014, Inspector #148 observed there to be no resident-staff communication system (otherwise known as a call bell system) available in the large dining room, which is used for resident meal service.

In the company of the DES on July 31, 2014, it was confirmed that the large dining room, does not have a resident-staff communication system. The DES reported that the home was informed during an assessment by Cintel, a telecommunications company used by the home, that a call bell was required in the dining room, however the home has not installed a call bell at this time. [s. 17. (1) (e)]

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 homes resident-staff communication and response system is available in every area accessible by residents, including the resident's dining room, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee failed to comply with O.Reg 79/10, s. 229(4), whereby the licensee did not ensure that all staff participate in the implementation of the program.

As confirmed by Inspector #549 the home has an infection control program that includes best practice isolation precautions.

On the morning of July 29, 2014, Inspector #148 observed an isolation cart located

just inside of a resident bedroom. PSW Staff #S116 was observed to be exiting the room holding a meal tray. Staff #S116 reported to Inspector #148 that she had just completed feeding breakfast to Resident #14 who was in bed. When asked by the Inspector, Staff #S116 was not aware which resident in the two bed semi-private room the isolation cart was for or what precautions were required.

Inspector #148 spoke with RN Staff #S100, who reported that Resident #14 has an MRSA infection of a wound and is on contact precautions.

Staff #116 did not participate in the implementation of the infection prevention and control program as it relates to contact precautions.

As confirmed by Inspector #549 the home has an infection control program that includes a hand hygiene program.

On August 1, 2014, during the lunch meal service, Inspector #148 observed PSW Staff #S109 not to participate in the home's hand hygiene program. Staff #S109 was observed to be responsible for the meal service of two resident tables. Staff #S109 was observed to serve food to residents, clear dirty dishes from the resident tables and provide feeding assistance to six of the eight residents at these tables. At no time was Staff #S109 observed to wash his/her hands during the meal service. At one point early in the meal service, the staff member was observed to use a Prevail wet wipe to wipe his/her hands. It was confirmed that the wipes are not antibacterial and are primarily for the use of residents to wash their hands and face after the meal.

On August 1, 2014, during the lunch meal service, Inspector #599 observed PSW Staff #S117 not to participate in the home's hand hygiene program. Staff #S117 was observed to porter a resident into the dining room, remove the foot petals of the resident's wheelchair then proceed to obtain plates of food to serve residents. Staff #S117 was observed to continue to serve food to residents, clear dirty dishes from resident tables and provide feeding assistance to residents. At no time was Staff #S117 observed to wash her hands during the meal service. (#559)

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 all staff participate in the implementation of the home's hand hygiene program and isolation procedures, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.31(2) 4 and 5, whereby the licensee did not ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining and the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

The plan of care for Resident #12 indicates that a basic seat belt will be used when the resident is up in his/her wheelchair for safety and to prevent the risk of falls.

On July 20, 2014, Inspector #148 observed Resident #12 in his/her wheelchair with a seat belt applied. On the morning of August 1, 2014, Inspector #148 spoke to the resident on three occasions, as well as PSW #S114, who was responsible for the resident's care, and the ADOC, and confirmed that the resident is not able to physically and cognitively able to remove the seat belt. The purpose of the belt was confirmed to be used for both safety and positioning. The seat belt is therefore, defined as a restraint under section 31 of the Act.

A review of the health care record demonstrated that there is no current order for the use of a restraint nor is there a documented consent from the resident or substitute decision maker. The ADOC reported to the Inspector that she had a previous understanding that the resident could remove the seat belt and therefore a physician order and consent had not been obtained.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg. 79/10, s. 37 (a), (b) in that the licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items; and (b) cleaned as required.

On July 29, 2014 Inspector # 599 observed the following during the initial tour of the home:

In the residents' tub room: an unlabelled comb with some debris visible on the comb, an unlabelled hair brush, an unlabelled razor with visible hair in the razor, three unlabelled opened deodorant containers, an unlabelled small tube of calmoseptine (barrier cream), a washbasin containing two tubes of toothpaste opened unlabelled, an unlabelled bottle of Rose 31 perfumed body lotion, an opened unlabelled container of petroleum jelly, four bottles of opened hand and body lotion unlabelled, several hair pins sitting in the cupboard with visible hair in the pins, a container of Zincofax appeared to have the prescription label removed.

In a semi-private room, Inspector #549 observed an unlabelled hair brush with visible hair in the brush was sitting on the shelf in the residents' bathroom.

On Aug. 7, 2014 Inspector #549 observed the following in the residents' tub room: two unlabeled sticks of deodorant and a white unlabelled hairbrush with visible hair in the brush.

In a four bed room, Inspector #549 observed a white unlabelled hair brush with visible hair in the brush sitting on the shelf in the residents' shared bathroom. [s. 37. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.85(3), whereby the licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

On August 7, 2014, Inspector #148 spoke with the home's Resident Council president who reported that the home implemented the resident satisfaction survey in the spring of 2014. The Resident Council president reported that the survey was not presented to the council to seek their advice on the development and carrying out of the survey.

On August 8, 2014, Inspector #148 spoke with the home's Administrator who reported that the home implemented the resident satisfaction survey in April/May 2014. He further reported that the satisfaction survey was not presented to the resident council to seek their advice in the developing and carrying out of the satisfaction survey. [s. 85. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

The licensee failed to comply with O.Reg.79/10, s.110 (7) 7., whereby the licensee did not ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the every release of the device and all repositioning are documented.

In accordance Regulation 79/10 s.110(2), a resident who is restrained by a physical device shall be monitored every hour and released and repositioned at least once every 2 hours, while being restrained.

The plan of care for Resident #7 indicates the use of a basic seat belt as a restraint while seated in his/her wheelchair due to a risk of falls. The current Medication Administration Record confirms the use of the restraint while in the wheelchair.

During the course of this inspection, Inspector #148 observed Resident #7 in a wheelchair with the seat belt applied. On August 5, 2014, Inspector #148 confirmed with Resident #7 that he/she could not physically and cognitively remove the seat belt.

PSW Staff #S117 indicated that documentation related to the monitoring, release and repositioning of restraints is documented within Point of Care, as part of the home's electronic health care record. The restraint record pertaining to the seat belt from July 23 to August 6, 2014 was reviewed. The record indicates that on July 24, 25, 26, 28, 29, 30, August 1, 4 and 5, 2014 the seat belt was applied, the record further demonstrates the passing of 3-6 hours without documented release or repositioning of the resident while the safety belt is applied. [s. 110. (7) 7.]

Issued on this 22nd day of August, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN SMID (161), AMANDA NIXON (148), HUMPHREY JACQUES (599), RENA BOWEN (549)
Inspection No. / No de l'inspection :	2014_199161_0017
Log No. / Registre no:	O-000711-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 15, 2014
Licensee / Titulaire de permis :	HILLTOP MANOR NURSING HOME LIMITED 82 Colonel By Crescent, Smiths Falls, ON, K7A-5B6
LTC Home / Foyer de SLD :	HILLTOP MANOR NURSING HOME LIMITED 1005 ST LAWRENCE STREET, P.O. BOX 430, MERRICKVILLE, ON, K0G-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jim Parsons

To HILLTOP MANOR NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare,submit and implement a plan for achieving compliance to ensure that Resident #14's pain is reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective.

A written plan for achieving compliance is to be prepared and submitted by August 22, 2014. At a minimum, the plan must identify:

A detailed description of the content of a comprehensive staff educational program that reflects all aspects of the requirements set in the legislation related to pain management including:

1. The home's pain management program
2. Legislative references O. Reg. 79/10, s. 52
3. Pharmacodynamics of opiod therapy.
4. Names of person(s) accountable for each component of this staff education program.
5. A monitoring system to ensure that staff have acquired the knowledge and is effective.
6. Time frames for this education including the start date with a finish date of no later than September 30, 2014.

The plan is to be submitted to Kathleen Smid Long Term Care Homes Inspector Nursing, Ottawa Service Area Office by August 22, 2014 via fax # 613.569.9670.

Grounds / Motifs :

1. The licensee had failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(10) (c) in that the licensee did not ensure that Resident #14 was reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective.

Resident #14 has an extensive leg wound involving the left lower leg and heel. On a specified date in July 2014 the Resident was assessed by a vascular surgeon regarding treatment of his/her leg wound. The surgeon concluded that a possible amputation of Resident #14's left lower leg might be necessary for pain control. The South East Palliative Pain and Symptom Management Consultation service has been following Resident #14 for pain management. On the most recent RAI-MDS 2.0 assessment Resident #14 scored 3 out 3 on the Pain Scale, indicating daily horrible or excruciating pain.

Resident #14's pain is assessed using the Pain Assessment in Advanced Dementia scale (PAINAD) that had been recommended by the South East Palliative Pain and Symptom Management Consultant. On August 5, 2014 Inspector #161 asked for and received from the Director of Care, copies of Resident #14's PAINADs completed for June, July and August 1 – 5, 2014. These were subsequently reviewed by Inspector #161 and the results are detailed below.

From June 6 to August 5, 2014 the PAINAD tool was used 65 times to assess Resident #14's pain. The results indicated that Resident #14 was experiencing moderate to severe pain 54/65 times. A review of Resident #14's health care record including physician's orders, physician notes, medication administration record, progress notes and care plan for June 2014 indicated that there had been no changes in the Resident's plan of care related to effective pain management strategies.

On August 5, 2014 at approximately 10:20 a.m. Inspector #161 and # 549 observed Resident #14 lying in bed with facial grimacing and moaning loudly. Inspector #549 asked the Resident if he/she was alright. Resident #14 stated that he/she was having "terrible pain in his/her left leg below the knee." The Resident's lower legs had been uncovered by RPN #S105 and a PSW in preparation for an imminent dressing change to his/her left lower leg. When the PSW lifted Resident #14's right leg to move it slightly so as to provide better access to the Resident's left lower leg, Resident #14 cried out in pain. Inspector #161 interrupted RPN #S105's ongoing preparation for Resident #14's dressing change when she asked RPN #S105 if the Resident had received any pain medication in anticipation of this dressing change. RPN #S105 indicated to Inspectors #161 and #549 that she had administered Hydromorphone to Resident #14 approximately one hour ago. She then stated to the Inspectors that she would check to see if Resident #14 could be given more analgesia which she would administer, then wait for the analgesia to be effective and change the Resident's dressing.

A review of Resident #14's Medication Administration Record indicated that on August 5, 2014 the Resident had received Hydromorphone 0.5 mg at 08:20 which was two hours prior to the dressing change planned for 10:20 on August 5, 2014.

On August 5, 2014 at 10:27, Inspector #161 discussed the observations made

with regard to ineffective pain management for Resident #14's dressing change with the Associate Director of Care. She immediately facilitated changes in Resident #14's plan of care related to pain management which included the following:

On August 5, 2014 at 10:30, the attending physician was notified by telephone and ordered a short acting benzodiazepine to be administered 15 minutes prior to Resident #14's left leg dressing changes.

On August 6, 2014 morning, the Palliative Pain and Symptom Management Consultant assessed Resident #14 and provided recommendations to the health care team at the home which included the need for a more aggressive approach to pain management. The attending physician who was in the home at the time agreed to further changes in medications.

Resident #14's pain was not reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

The licensee has a history of non-compliance with LTCHA 2007 S.O. 2007, c.8, s.6(10)(b) related to pain management. A Compliance Order was issued on August 13, 2012 as a result of inspection #2012-039126-0001
(161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall ensure that all drugs are administered to all Residents in accordance with the directions for use specified by the prescriber. This includes an audit of the Medication Administration Records of all Residents as well as an audit of the home's document titled "Medications not Administered" and Immediate action to be taken if there are any discrepancies. A record of these audits will be made available to the Long Term Care Home's Inspector during the follow-up to this order.

Grounds / Motifs :

1. The licensee has failed to comply with O.Reg 79/10 r. 131(2) in that the licensee did not ensure that drugs are administered to Resident #14 in accordance with the directions for use specified by the prescriber.

Resident #14 has an extensive leg wound involving the Resident's left lower leg and heel. On a specified date in July 12014 the Resident was assessed by a vascular surgeon regarding treatment of the leg wound. The surgeon concluded that that a possible amputation of Resident #14's left lower leg might be necessary for pain control. The South East Palliative Pain and Symptom Management Consultation service has been following Resident #14 for pain management. On the most recent RAI-MDS 2.0 assessment (July 8, 2014), Resident #14 scored 3 out 3 on the Pain Scale, indicating daily horrible or excruciating pain.

The Physician's Orders dated June 6, 2014 state that Resident #14 is to receive Hydromorphone 1 mg by mouth every 4 hours around the clock. If the Resident is unable to swallow the Hydromorphone by mouth, Resident #14 is to receive this medication subcutaneously every 4 hours around the clock. The

Hydromorphone 1 mg is to be administered to Resident #14 at midnight, 4:00 a.m., 8:00 a.m., noon, 4:00 p.m., and 8:00 p.m.

Resident #14's Medication Administration Records for the months of June, July, and August 1 -5, 2014 were reviewed by Inspector #161 and the home's ADOC. From June 1 – August 5, 2014, Resident #14 was not administered her scheduled Hydromorphone 1 mg on 13 occasions.

A review of the home's "Medications not Administered" document which Registered Staff use for documenting reasons for not administering medications was reviewed for June, July, and August 1 – 5, 2014. All entries in this document indicated that Resident #14 was not administered Hydromorphone 1 mg every four hours around the clock because the Resident was sleeping. This was verified by the ADOC.

On August 7, 2014 the ADOC indicated to Inspector #161 that upon recommendation by the South East Palliative Pain and Symptom Management Consultant, the home uses the Pain Assessment in Advanced Dementia Scale (PAINAD) tool to assess Resident 14's pain.

Hence, the dates in June, July, August 1 -5, 2014 when Resident #14 did not receive his/her scheduled Hydromorphone, were compared to the PAINAD assessments conducted on/near those dates. On the 13 occasions that Resident #14 did not receive his/her scheduled Hydromorphone, all PAINAD Summary scores indicated that the Resident was experiencing moderate to severe pain.

Resident #14 was not administered Hydormorphone 1 mg every 4 hours around the clock in June, July and August 1 – 5, 2014 in accordance with the directions for use specified by the prescriber. [log # O-000758-14]

The licensee has a history of non-compliance with O.Reg 79/10 r. 131(2) A Voluntary Plan of Corrective Action (VPC) was issued on August 4, 2012 as a result of inspection #2012-039126-0001. [s. 131. (2)]
(161)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 22, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 15th day of August, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KATHLEEN SMID

Service Area Office /
Bureau régional de services : Ottawa Service Area Office