Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Sep 10, 2020	2020_704682_0008	001495-20, 007269-20, 009329-20, 010311-20, 010672-20, 014147-20	Critical Incident System

Licensee/Titulaire de permis

Maryban Holdings Ltd.
3700 Billings Court BURLINGTON ON L7N 3N6

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

Oakwood Park Lodge
6747 Oakwood Drive NIAGARA FALLS ON L2G 0J3

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

AILEEN GRABA (682), DARIA TRZOS (561), LISA BOS (683)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 23, 24, 27, 28, 29, 30, 31, August 6, 7, 10, 11, 12, 13, 14, 18, 19, 20, 21, 2020.

PLEASE NOTE:
A Voluntary Plan of Correction (VPC) related to LTCHA s.6. (11) and a Voluntary Plan of Correction (VPC) related to LTCHA s. 5., were identified in this inspection and have been issued in inspection report #2020_704682_0007, which was conducted concurrently with this inspection.

The following intakes were completed during this Critical Incident System inspection:
001495-20 related to medication
010311-20 related to medication
007269-20 related to prevention of falls
009329-20 related to prevention of falls
010672-20 related to prevention of falls
014147-20 related to prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) reviewed resident clinical records, policies and procedures, investigation notes, staff education and training records, staffing schedule and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **1 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 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 failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A clinical review included the resident's care plan and identified a focus for pain with some pain relief interventions. A review of progress notes identified the resident had requested pain medication and the RPN administered prescribed medication. Progress notes documented by the RPN indicated that the resident continued to experience increased pain after the medication administration. Further clinical record review did not include a pain assessment at the time when the resident's pain had not been relieved by initial interventions.

During an interview, the Director of Care (DOC) acknowledged that a pain scale assessment should have been completed. The home failed to ensure that the resident's pain was assessed using a clinically appropriate assessment instrument when their pain was not relieved with initial interventions. [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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices, to minimize risk to the resident.

A review of the clinical record for the resident indicated that they sustained a fall. Their written plan of care indicated that they were a risk of falls. At the time, they used an assistive device while in bed for bed mobility. A progress note documented by the RPN indicated that they received consent for the assistive device and the clinical records were updated. The resident was observed in bed with the assistive device in place. A review of the resident's clinical record did not identify a bedrail assessment. In an interview with the RPN, they indicated that when the assistive device was added they updated the clinical records but were unsure if a bed rail assessment needed to be re-done. In an interview with the DOC, they acknowledged that a bed rail assessment should have been completed for the resident and they acknowledged that upon their review of the resident's clinical record, there was no assessment completed. The home did not ensure that the resident was assessed to minimize risk to the resident. [s. 15. (1) (a)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

A resident was observed by Inspector #683 with a PASD in place. The PSW confirmed that the PASD was in place at the time. A review of the resident's written plan of care, did not identify the use of a PASD. Inspector #683 asked the resident if they could remove the PASD, and they indicated that they could not. In an interview with the DOC, they acknowledged that the resident was not assessed for the use of a PASD and acknowledged that it was not in their plan of care. The resident was observed with a PASD in place which had the effect of limiting or inhibiting their freedom of movement. The resident was not able to consistently release themselves from the device and the home did not ensure that it was included in their plan of care. [s. 33. (3)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident had been assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A progress note indicated that a resident was found by a PSW on the floor. Clinical records were reviewed and the post fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls, was not completed for this fall. A registered staff was interviewed and stated that based on the homes policy, if a resident was found on the floor then this was to be considered a fall and a post fall assessment was to be completed.

The ADOC was interviewed and stated that if the resident was on the floor, it should be considered a fall, and a post fall assessment should have been completed. The home failed to ensure that when a resident fell, a post fall assessment was completed using clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the home's medication management system, drugs of a controlled substance were destroyed by a team acting together and composed of:
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist

A review of the investigative notes indicated that a RPN identified and reported that a controlled medication was missing. An investigation was completed by the DOC and the RPN and the medication was not found. During an interview the DOC confirmed that the missing medication was never found. The DOC confirmed that the home failed to ensure that drugs of a controlled substance were destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist. [s. 136. (3) (a)]

Issued on this 11th day of September, 2020

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

Original report signed by the inspector.