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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 20, 2018	2017_532590_0024	031454-16, 033002-16	Complaint

Licensee/Titulaire de permis

MERITAS CARE CORPORATION
567 VICTORIA AVENUE WINDSOR ON N9A 4N1

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

REGENCY PARK LONG TERM CARE HOME
567 VICTORIA AVENUE WINDSOR ON N9A 4N1

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

ALICIA MARLATT (590)

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): November 6 - 10 and 13, 2017.

The following intakes were inspected concurrently:

Complaint inspection: Log #031454-16/IL-48809-LO was related to falls prevention and management and prevention of abuse and neglect;
Complaint inspection: Log #033002-16/IL-48073-LO was related to medication management and resident rights;
Critical Incident System (CIS) inspection: Log #030824-16/CIS #2760-000013-16 was related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, two Registered Nurses (RN), two Registered Practical Nurses (RPN), three Personal Support Workers (PSW), two Health Care Aides, one family member and one resident.

During the course of the inspection, the inspector(s) reviewed one resident's clinical record, one Critical Incident System report, the home's pain and falls management policies and the home's internal investigation notes.

During the course of the inspection, the inspector(s) observed infection prevention and control practices, the provision of resident care, staff and resident interactions and one resident's room.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ontario Regulation 79/10, s. 30 states that "every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

Under Ontario Regulation 79/10, s. 48, required programs, "every licensee of a long-term care home shall ensure that a pain management program to identify pain in residents and manage pain is developed and implemented in the home."

The home's policy titled "Pain Management Program" last revised in March 2015, stated in part that:
"A comprehensive pain assessment will be done to assess and determine interventions and pain management planning. This assessment will be completed: On Admission within 24 hours by registered staff, if there is a change in the resident's condition where a new pain is a symptom of an illness (i.e. injury, new open wound, significant change in status, etc.) and with new pain site or complaint of a new pain." The section of the policy that outlined how to complete the pain assessment stated that: "Registered staff shall complete an assessment of the resident's pain status at the beginning of each shift (D, E, and N) of the five day tracking process, at a minimum of twice per shift. If the resident requires pain management including non pharmaceutical or analgesic treatment,

Registered Staff are to note the time frame under shift and note time intervention was provided, then reassess resident's pain status within the time frames noted above for when medication or treatment should be taking effect post pain management intervention, i.e. half hour-45 minutes for oral analgesics, and note in evaluation."

An identified resident experienced a fall in the early morning hours on a specific date, and was sent to the hospital in the late morning hours the next day, for further assessment due to consistent complaints of pain to an identified site. The post-fall assessment that was completed immediately after the fall documented that the resident was found to have pain to an identified site, but had full range of motion to the extremity and no visible injuries were observed. Review of progress notes from the time of the fall to the residents hospitalization, showed that there were five entries written that referenced the residents complaints of pain.

The resident returned from the hospital on a specified date, after having surgery.

Review of this resident’s paper documentation showed that the five day pain tracking assessment was initiated and completed on specified dates, however was not fully completed. There was no documentation completed on the day when the resident returned from the hospital. Two night areas and one area on the evening shift on a specified date had no documentation on the assessment form. On another specified date, both day shift areas had no documentation completed.

Review of this resident’s electronic documentation showed that a comprehensive pain assessment was completed on a specified date.

There was also no documented pain assessment that was initiated after the resident's fall.

In an interview with a RPN, they explained that pain assessments were completed on days when there were new pain medications added, after a fall, or if a resident was gone for more than 24 hours.

In an interview with a RN, they said that pain assessments were completed on admission, with any new pain, with a new pain medication, or when the resident was asking for pain medication. The RN explained that when a resident fell, the nurse would assess the resident for pain during the post-fall assessment, and if there was no immediate sign of fracture, they would continue to monitor pain for at least 72 hours,

which would be documented on the paper pain assessment tool or in progress notes. The RN said that if a resident complained of pain after a fall, a pain assessment (paper) should be initiated to monitor their pain.

In an interview with the DOC, they stated that the post-fall assessment in Point Click Care (PCC) was completed when a resident fell and included an assessment of pain, and if pain was identified within the post-fall assessment, a pain assessment (paper) should be initiated. The DOC further said that this was subject to nursing judgement and that a pain assessment should be completed for residents on admission and for new symptoms of acute pain. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

This inspection was initiated as a result of a complaint #IL-48073-LO, submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to medication management concerns.

In an interview with a family member of an identified resident, they shared that they received a phone call from the home that their family member was sent to the hospital after receiving too much medication on a specified date. The family member stated that they were unsure of what really happened and wanted to know the details so they called the MOHLTC to investigate the incident.

Review of this resident's electronic Medication Administration Record (eMAR) for the identified time frame, showed that the resident had at that time, a physician's order for an identified narcotic to be administered three times a day and an order to also take the narcotic every three hours as needed. This resident had received their regularly scheduled narcotics throughout the day on a specific date. The eMAR showed that the resident received one dose of narcotics at a specific time and was documented as being effective for pain management. Another dose of narcotics were given to the resident at a specific time and was documented as being ineffective for pain management. The resident was given another dose of narcotics at a specific time and the effect was documented as unknown.

Review of this resident's progress notes for a three day time period surrounding the incident was completed. There were no documented notes on one identified day. There was one note documented on a specific date in the evening that was unrelated to the incident. The next note was the first note of that day and was documented after the resident had left for the hospital. This note documented, in summary, that the resident was confused, would not follow instructions as normal and that a PSW notified the registered staff of the resident's behaviours. The note also documented that narcotics were given to the resident earlier on in the shift and documented vital signs which showed a low blood pressure reading and a low oxygen saturation level. An assessment documented in this note stated that the resident was pale, diaphoretic and short of breath, and had been sent to the hospital earlier.

A RPN said in an interview, that if a narcotic was ordered as needed every three hours, there was room to give the medication a half hour before or after the time frame if the resident was in excruciating pain. The RPN continued that if they administered a narcotic earlier than ordered, they would address this with the physician to obtain guidance and to find solutions for the resident's pain management.

RN was interviewed and stated that they followed the standard of administering medications, including narcotics, up to 30 minutes before or after the time per the physician's orders. The RN shared that they would observe the resident's reaction to the medication, for example any sleepiness or pain, document any reactions and notify physician to reassess the resident as needed. The RN said that if a resident had an order for as needed narcotics every three hours and the resident was complaining of pain, they could provide the medication after two and a half hours but would notify the physician if it became a pattern for the resident to complain of pain prior to the next dose, so the physician could reassess the resident's pain management.

In an interview with the Administrator, the inspector asked for any other documentation to support that this resident had been monitored between the time period when the resident received their last dose of pain medicine and when they went to the hospital. The Administrator shared that pain levels were documented on the eMAR for all 'as needed' administered analgesics. The inspector communicated to the Administrator that the last documented dose of narcotics administered, documented the effectiveness of the medicine as unknown and was why a request for more information was made. The Administrator could not provide any other documentation to support that the resident was monitored between the time frame of when narcotics were administered at the identified time and when the resident was sent to the hospital. The inspector clarified that the effectiveness was documented as unknown on the eMAR and there was no other documentation that was reflective of the residents responses to, or the effectiveness of the medication. The Administrator agreed that there was no written record to support that this resident was monitored after receiving the last dose of medication. [s. 134. (a)]

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 for the resident taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

Complaint #IL-48073-LO was received by the MOHLTC on a specified date, from a family member that identified concerns with how long it took the home to notify them of a change in their loved ones condition and their subsequent hospitalization. The family member shared with the inspector that their loved one was sent to the hospital around 0500 or 0600 hours in the morning on a specific day, and that they were not notified of the events until approximately 1030 hours that morning.

A progress note written on a specific date showed that an identified resident was experiencing difficulties at the home and was sent to the hospital for further assessment at 0430 hours. The note stated that the day shift would call the resident’s power of attorney (POA).

A progress note written on the identified date, documented that this resident’s POA was called at that time of their hospitalization and that the family member was upset about this.

In an interview with a RPN, they shared that registered staff members were responsible for immediately calling the family for any resident going to the hospital unexpectedly, especially if their condition was declining.

In an interview with a RPN, they explained that they would call the physician and call the family immediately if the resident was being sent to hospital.

In an interview with the DOC, they clarified that if a resident required a transfer to hospital, the POA should be notified immediately, regardless of the time of day. [s.3. (1) 16.]

Issued on this 20th day of February, 2018

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

Original report signed by the inspector.