Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 16, 2017	2017_532590_0014	009032-17, 010183-17	Complaint

Licensee/Titulaire de permis

RICHMOND TERRACE LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

RICHMOND TERRACE
89 RANKIN AVENUE AMHERSTBURG ON N9V 1E7

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

ALICIA MARLATT (590), AMIE GIBBS-WARD (630)

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): July 12, 13, 14, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nutrition Manager, the Programs Director, a Registered Dietitian, one Recreation Aide, one Dietary Aide, a Constable from Amherstburg Police Service, one Registered Nurse, three Registered Practical Nurses and three Personal Support Workers.

During the course of the inspection, the inspector(s) observed staff and resident interactions, infection prevention and control practices, dining services, recreational activities and the provision of resident care and reviewed two resident clinical records, relevant policies and procedures related to the inspection, email correspondence related to the inspection, Infoline reports and Critical Incident reports.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Food Quality
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the SDM (Substitute Decision Maker), if any, and the designate of the resident / SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was received by the Ministry of Health and Long Term Care from a resident's family member, who was concerned that the resident was prescribed a specific medication. This resident’s family member stated that they had informed the home on admission that the resident could not be on some types of medications. This family member shared that they were unaware of the resident being put on a specified medication until the resident was admitted to the hospital.

Review of this identified resident's digital prescription orders showed that the physician ordered a specific medication on a specified date. The consent box to inform staff that the resident or their SDM had been made aware of the medication was not initialled.

In an interview with the Director of Care (DOC), they said that Medical Pharmacies provides all their medication policies and they do not have a policy that directs staff to notify resident's or SDM's of medication changes. The DOC shared that no documentation was provided to the home from the family which directed that the resident could not be started on certain types of medications. The DOC stated that regardless of not having a policy outlining this specific action, the registered staff are educated that notifying resident's and/or their SDM's of medication changes were part of processing a physician's order at Richmond Terrace.

The licensee failed to ensure that the resident, the SDM (Substitute Decision Maker), if any, and the designate of the resident / SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

The severity of this non-compliance was determined to be a level two. The scope of this issue was identified as an isolated incident. The home has a history of this area of legislation being issued in the home on November 10, 2015, as a Voluntary Plan of Correction in a Critical Incident Inspection #2015_276537_0047. [s. 6. (5)]

WN #2: 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 is:
(a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and
(b) complied with

Ontario Regulation 79/10 s. 48 (1) 4. states that "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A pain management program to identify pain in residents and manage pain."

A resident's family member identified concerns regarding pain management. The family member felt the home was not appropriately assessing this resident's pain.

Record review showed that the identified resident was experiencing pain and was taking regularly scheduled analgesics. This resident is cognitively impaired and cannot express their needs, wants or feelings to others.

Review of progress notes showed that on a specified date, the resident was experiencing pain and this was communicated to the physician by the resident's family. The family stated that the resident was taking a larger dose of analgesic medication in the morning prior to moving into the home. At that time, the physician increased the dosage of the morning analgesics, so the resident was then receiving analgesics as requested by the family.

Review the home's policy titled "Corporate Pain Management Program" states in part

that "The Pain Assessment Tool (medication follow-up) is completed once a shift for 72 hours following a pain medication change, addition or dosage adjustment.".

Review of this resident's completed pain assessments showed that the resident was assessed for pain using an appropriate tool at three different times, however was not assessed using an appropriate tool when the change in dosage of analgesic was initiated on the specified date.

In an interview with the DOC, they shared that the home does have a pain program in place. They said that pain assessments are to be completed as per the homes policy and agreed that this resident's pain assessments were not completed using an appropriate tool when the changes in analgesic dosages occurred on the specified date, but rather, the resident's pain was monitored with each administration of Tylenol on the electronic Medication Administration Record and in progress notes.

The licensee failed to ensure that the home's pain policy was complied with.

The severity of this non-compliance was determined to be a level one. The scope of this issue was identified as an isolated incident. The home has a history of unrelated non-compliance. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 17th day of August, 2017

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

Original report signed by the inspector.