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**
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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 17, 2013 | 2013_225126_0014 | O-000539-13 | Complaint |

**Licensee/Titulaire de permis**

SPECIALTY CARE OTTAWA INC.
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

SPECIALTY CARE GRANITE RIDGE
5501 Abbott Street East, Stittsville, ON, K2S-2C5

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

LINDA HARKINS (126)

**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): August 6, 7, 8, 9 2013**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, several Registered Nurses,several Registered Practical Nurses, several Personal Support Workers and two Assistant Physiotherapists**

**During the course of the inspection, the inspector(s) reviewed the resident health care record, the unit daily record, the medical directives,the pain and symptom Assessment and management Protocol VII-G-70.00 and the 24 hr pain and symptom monitoring tool.**

**The following Inspection Protocols were used during this inspection:**
**Pain**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend | Legendé |
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | 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.)<br><br>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.<br><br>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. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA 2007, S.O. 2207, c.8, S. 6. (11) (b) in that the home did not reassess Resident #1's plan of care related to pain management.

On the morning of a specified day in June, 2013, Resident #1 was observed to have pain on the left side of her/his arm/shoulder. RPN #109 was informed by PSW #103. RPN #109 assessed Resident #1. An analgesic was given to Resident #1 in the afternoon after lunch.Resident #1 was observed to be sleeping at the end of the day shift. The evening of that same day , it is documented in the progress note by S#110 that Resident #1 was observed wincing when his/her left arm was moved. No documentation of an analgesic administered or interventions to manage the discomfort observed. No documentation on the night shift related to Resident #1 health status.

The next morning of that specified day in June 2013, Resident #1 continued to be demonstrating discomfort when his/her left arm was touched. An analgesic was administered in the morning and no effectiveness documented. During the evening of that same day, it was documented that Resident #1 winced when his/her left arm was touched and that his/her arm was warm to touch. No documentation of an analgesic given or interventions to manage the discomfort observed. No documentation on the night shift related to Resident #1 health status.

Two days after the initial complaint of pain, Resident #1 continued to exhibit pain (facial grimacing) when left hand/forearm was touched. An analgesic was given with effect. Registered Nurses #111 and #112 were notified and an order was received from the physician to start an antibiotic. It was noted in the progress note that Resident #1 continued to exhibit signs of pain with facial grimacing. Evening RPN #110 administered an analgesic with effectiveness. No documentation on the night shift related to Resident #1 health status.

Three days after the initial complaint, Resident #1 was given an analgesic for discomfort around supper time with good effect. No other documentation in the progress notes during that day related to pain management. No documentation on the night shift related to Resident #1 health status.

Four days after the initial complaint, four doses of an analgesic was given during the day and evening shift. Two of the doses were documented to be effective however it

was noted that Resident #1 continued to be wincing by demonstrating pain by facial grimacing.

On the fifth day of the initial complaint of pain, two doses of an analgesic was given by S #109 with no effect documented as unable to assess the result of the effectiveness of the medication because Resident #1 was unable to communicate. On the evening of that same day, PSW reported to S# 110 that Resident #1 was cringing when he/she came to get her at 15:30. An analgesic was given at 18:56 with no documentation of the effectiveness of the analgesic. Resident #1 was transferred to the hospital as per Power of Attorney request for further assessment of the left arm. Resident #1 was diagnosed with a left dislocated shoulder.

Discussion held with RPN S #109 indicated that he/she was informed of Resident #1 pain on the initial day of the complaint of pain at breakfast time and an analgesic was administered after lunch. After reviewing the Medication Administration Record for that day, he/she indicated that he/she was sure he/she had given Resident #1 analgesic at breakfast time. No documentation found in the resident health care record about the administration of the analgesic the morning of that specified day in June 2013.

Resident #1 has been exhibiting pain, discomfort, wincing, facial grimacing when his/her left arm was touched as of the morning of that initial day the complaint on that specified day in June 2013. Several doses of an analgesic was administered over the course of several days without controlling Resident #1's pain in his/her arm. [s. 6. (11) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure ongoing effective pain management monitoring and interventions are implemented in the home as per the home policy requirements., to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

**s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10 s. 52. (2) in that the licensee did not ensure when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument.

Resident #1 started to exhibit left arm/shoulder pain the morning of specified day in June 2013. Resident #1 was treated with an analgesic occasionally with no effectiveness documented on several occasions and continued to exhibit pain until the transfer to hospital five days later.

The home's policy "Pain and Symptom-Assessment and management protocol" policy # VII-G-70.00 requires that the Registered Staff utilize the Point Click Care (PCC) assessment tool and the 24 hr pain and Symptom Monitoring Tool . Between the period of June 8-13, 2013, Resident #1 was not assessed with those tools as per the home's policy requirements. [s. 52. (2)]

**Issued on this 17th day of September, 2013**

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