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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 3, 2022	2022_966755_0002	018368-21	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Montfort
705 Montreal Road Ottawa ON K1K 0M9

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

MANON NIGHBOR (755)

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): February 8-11, 2022.

A complaint was received by the Ministry of Long Term Care related to a resident's pain control and care issues.

During this inspection the following log was inspected: Log # 018368-21 related to resident's change in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Environmental Services Manager, Infection Prevention and Control (IPAC) Specialist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and housekeeping staff.

During the course of the inspection, the inspector observed residents and staff interactions related to care and services, emergency drug box, reviewed relevant clinical health records, pain assessment tool directives and, interviewed staff.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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 :

The licensee has failed to ensure that the policy, procedure and or pain management system, is complied with.

The resident was at high risk of developing complications due to their medical condition and history. They demonstrated a new onset of pain.

The pain assessment tool, stated that its purpose is to guarantee resident's pain is monitored and controlled. The tool is to be initiated when a new uncontrolled pain appears. It is to be filled out for 72 hours.

The progress notes indicated that the resident complained of pain which they were treated and the intervention was found to have been effective. Later that day, the progress notes described the resident complained of pain again. A staff member confirmed that they had administered an analgesic as described in the progress notes but after reviewing the electronic medication record (EMAR), the administration had not been recorded. Therefore, a reassessment of the resident's pain level was not automatically triggered for the staff to assess the analgesic's efficacy.

A pain assessment tool, was not initiated. Two staff members confirmed that the pain assessment tool should have been initiated, as per its usage directive.

The next day, the resident complained of pain. There was no record of any analgesic administered . A staff member stated that they felt the resident was in pain as the resident had facial grimacing. The assessor shared that the resident only had discomfort. The next day, the resident was transferred to the hospital and later died in hospital.

Source:
Progress notes, EMAR and pain assessment tool.
Interviews with multiple staff members.

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 policy, procedure and or pain management system, is complied with, to be implemented voluntarily.

WN #2: 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. (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 has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when, the resident's care needs changed and when care set out in the plan had not been effective.

The resident was experiencing symptoms for some time, they were at high risk of developing complications due to their medical condition and history.

The progress notes described the resident had a new onset of symptoms. Their pain was addressed and the treatment was effective, although other symptoms were observed. The plan of care was otherwise unchanged at that time. Later that day, resident's pain returned which was addressed. A staff member said they advised the RN about the resident's symptoms. There was no assessment documentation found from the RN.

The next day, the resident's symptoms worsened. They were treated, although there was an element of risk that was not addressed.

There was no assessment documented in the progress notes for many hours until resident's condition had deteriorated. A staff member, confirmed that during that period, especially since resident's health status was changing, a documented assessment and revision of their plan of care should have been indicated in the progress notes. The resident was transferred to the hospital and later died in hospital.

Source:
Progress notes, electronic medication record (EMAR), Registered Nurses Association of Ontario's best practices.
Interviews with staff members and coroner.

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 resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: 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 ensure that a medication was administered in accordance with the directions for use specified by the prescriber.

The resident was at high risk of developing complication due to their medical condition and history.

The resident started to demonstrate symptoms and continued to exhibit symptoms. A medication was prescribed and was to start later that day. A staff member explained that when a medication is administered later in the day, the pharmacy will deliver the medication or staff can obtain the medication from the emergency drug box. Two staff members confirmed that this medication was available in the home's emergency drug box. The first dose was administered the next day.

Later that day, resident's condition had deteriorated, the doctor was called and the resident was transferred to the hospital and later died.

Source:
Progress notes, electronic medication record, urgent medication box.
Interviews with two staff members.

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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 4th day of March, 2022

[redacted]

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

Original report signed by the inspector.