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

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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
Aug 8, 2014	2014_285546_0017	O-000369-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

SUSAN WENDT (546)

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): August 6, 7, 8, 2014

in response to log # O-000369-14 for CI 2886-000020-14

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care and one Registered Nurse.

During the course of the inspection, the inspector(s) reviewed the resident's Health record, Medication Administration record, the Home's Pain Management Program and policies.

The following Inspection Protocols were used during this inspection:
Pain
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 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 the resident, whose pain was not relieved by initial interventions, was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A review of the progress notes from April 2014 revealed that the resident complained of severe pain in the right foot in excess of 15 times and was medicated with Ibuprofen with varying degrees of relief. During those dates, the resident refused to get up in the morning, refused to stand and refused to participate in activities, however, there was no documentation to indicate that the resident's pain was assessed to identify the cause, despite the ankle being bruised and swollen. An x-ray of the resident's foot was done on a specific date in April 2014 and a cast was applied to the foot for the fractured distal tibia. The resident's pain subsided after the cast was applied.

During an interview with Inspector #546 on a specific date in August 2014, in the presence of the Executive Director and DOC, S#100 confirmed that no head to toe assessment was completed on resident #001 when the resident complained of pain in the foot. When asked if there was a pain assessment completed, S#100 could not recall.

Upon review of the resident's health record, Inspector #546 found no pain assessments.

Thus, the licensee failed to ensure that the resident's pain was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [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 that all residents, whose pain is not relieved by initial interventions, are assessed using a clinically appropriate assessment instrument specifically designed for this purpose., to be implemented voluntarily.

Issued on this 8th day of August, 2014

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