Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 4, 2019	2019_725522_0012	014708-19, 015108-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Port Stanley
4551 East Road PORT STANLEY ON N5L 1J6

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

JULIE LAMPMAN (522)

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 22, 23, 26, and 27, 2019.

The following critical incidents were inspected during this inspection:

Critical Incident System (CIS) report #2669-000009-19 related to falls prevention; CIS report #2669-000008-19 related to improper care.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Program Manager, the Resident Assessment Instrument (RAI) Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

The inspector also observed the provision of resident care, reviewed resident clinical records and policies and procedures related to the inspection.

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)**
- **1 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	Légende 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 has failed to ensure when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to the improper care of resident #002.

Review of the CIS noted resident #002 had a witnessed fall on a specified date. The CIS noted after the fall pain assessments where not completed for resident #002.

Review of resident #002's progress notes noted on four consecutive days after resident #002's fall, the resident displayed behaviours of new and increasing pain. Resident #002 was seen by the physician on the fourth day post fall and analgesia was ordered as needed for the resident's pain.

Review of resident #002's electronic clinical record in Point Click Care (PCC) noted the resident had not received a pain assessment until six days post fall.

In an interview, Registered Practical Nurse (RPN) #104 stated that a pain assessment would be completed on a resident who had new pain. RPN #104 stated if a resident was cognitively impaired they would look at their body language to determine if they were in pain and the home used the PAINAD tool for cognitively impaired residents to determine their level of pain.

RPN #104 stated that they had provided care to resident #002 after the resident's fall. RPN #104 stated that resident #002 had declined on their shift and the resident posed challenges to provide care, tried to strike out at staff and refused to be repositioned. RPN #104 stated they were thorough with inspecting the resident for injury and it was not new for the resident to display behaviours. RPN #104 stated they could tell resident #002 was having some discomfort and they did apply a rub on the resident's back. RPN #104 stated that they had not completed a pain assessment on the resident at that time.

In an interview, Personal Support Worker (PSW) #107 stated they had provided care to resident #002 after their fall. PSW #107 stated that they had noted a change in resident #002's behaviours after their fall. PSW #107 stated resident #002 was in pain and they had reported it to the Charge Nurse.

In an interview, Program Manager (PM) #103 and RAI Coordinator (RAI-C) #101 stated

that staff had not completed a pain assessment on resident #002 when they continued to have a change in behaviours and remained in bed after their fall.

PM #103 and RAI-C #101 stated when they spoke with staff regarding not completing a pain assessment for resident #002 after their fall, staff had indicated they assumed resident #002 was displaying behaviours which was not unusual for the resident. PM #103 stated staff did not think the change in the resident's behaviours was related to pain.

In an interview, Administrator/Director of Care #100 stated that staff should have completed a pain assessment on resident #002 when the resident continued to display signs of increased pain after their fall. [s. 52. (2)]

2. Review of resident #003's electronic clinical record noted resident #003 received two medications for pain control.

On a specific date, resident #003 was ordered an increase in one of their medications for pain control.

Review of resident #003's electronic Medication Administration Record (EMAR) for the administration of medical directives during a two month time period, noted as needed analgesic was administered to resident #003 regularly during a three week time period.

Review of resident #003's pain assessments in Point Click Care (PCC) noted no documented evidence that a pain assessment was completed when resident #003 had their medication for pain control increased or when resident #003 was regularly using medical directive analgesic.

In an interview, RPN #110 stated pain assessments were completed quarterly, and with any new signs and symptoms of pain. RPN #110 stated they would complete a Pain Assessment in Advanced Dementia (PAINAD) or pain flow note for five days then look back at all the pain flow notes and complete a full assessment.

In an interview, Registered Nurse #108 stated if a resident was having pain they would complete a Pain Flow Note and then a full pain assessment if they need to. RN #108 stated pain assessments were completed quarterly and if a resident was having new pain. RN #108 stated they would also do a pain assessment if a resident started a new pain medication to see if the medication was effective.

In an interview, Administrator/Director of Care (DOC) #100 reviewed resident #003's clinical record with inspector. Administrator/DOC #100 stated resident #003 should have had a pain assessment completed with the increased use of medical directive analgesia. Administrator/DOC #100 stated medical directives did not show up on the eMAR with the routine medications, so if staff were coming on shift they would not always know a resident was given analgesia from the medical directive. Administrator/DOC #100 also stated resident #003 should have had a pain assessment completed within 72 hours of the increase in medication for pain control.

The licensee has failed to ensure when resident #002 and #003's pain was not relieved by initial interventions, resident #002 and #003 were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to the improper care of resident #002.

Review of the CIS noted resident #002 had a witnessed fall on a specified date.

Resident #002's Pain/Palliation - Pain Assessments were reviewed.

One pain assessment noted resident #002's pain had started six days prior and noted the location of the resident's pain.

Another pain assessment completed the following day noted resident #002's pain had started the day of the assessment and did not indicate the location of resident #002's pain.

In an interview, Administrator/Director of Care (DOC) #100 reviewed resident #002's pain assessments with inspector. Administrator/DOC #100 stated that resident #002's pain assessments were not consistent.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #002 collaborated with each other in the assessment of resident #002 so that their pain assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to the improper care of resident #002.

Review of the CIS noted resident #002 had a witnessed fall on a specified date.

Resident #002's electronic clinical record noted several days after resident #002's fall a Safe Lift and Transfer Assessment was completed which indicated resident #002 had a change in mobility and transfer status.

Review of resident #002's most recent care plan noted resident #002's mobility and transfer status had not been updated.

In an interview, Personal Support Worker (PSW) #111 stated that since resident #002 fell they had a change in mobility and transfer status.

PSW #111 stated staff would be able to access resident #002's mobility status in Point of Care (POC). PSW #111 reviewed resident #002's Kardex in POC with inspector and confirmed that the information related to resident #002's mobility and transfer status had not been updated in the resident's care plan.

In an interview, Registered Practical Nurse #105 confirmed that resident #002 had a change in mobility and that registered staff should have updated resident #002's care plan to reflect this.

In an interview, Administrator/Director of Care (DOC) #100 stated that resident #002's plan of care should have been updated with their change in mobility. Administrator/DOC #100 stated the staff member who initiated the use of the mobility aid or the staff member who made the significant change would be the person who should have updated the care plan.

The licensee has failed to ensure that when resident #002 was reassessed after a fall their plan of care was reviewed and revised when resident #002 had a change in mobility. [s. 6. (10) (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 the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and that the resident is reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 79/10 s. 48. (1) 4 states, "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."

Ontario Regulation 79/10 s. 30. (1) states, "Every licensee of a long-term care home shall

ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 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."

A review of the home's policy "Pain Identification and Management" RC-19-01-01, last updated February 2017, noted in part:

"Use a 'Pain Flow Note' to document the completion of all required assessments and treatments and the resident's response to same, in addition to any other pertinent information related to the resident's pain care and treatment.

The nurse will assess resident's for pain using the Pain Flow Note in PCC (if resident is non-verbal or cognitively impaired, use the PAINAD to assist in completing the note).

A Pain Flow Note will be completed on all residents who meet any of the following criteria:
- Resident states the have pain;
- Any change in condition that has the potential to impact the resident pain level.

Notify the physician or nurse practitioner of the resident's pain including the analysis of the assessments if:
a. The resident reports sudden onset of new pain or worsening pain;
b. When more that three breakthrough pain medication doses are needed in a 24-hour period; and/or
c. The resident consistently reports pain for 24 hours."

Review of guidelines "What if someone has pain or has started a new pain med?" stated in part:

"You will complete a pain assessment. If the resident is cognitively impaired (advanced) not able to verbally respond or if they are able to respond they are unable to understand the questions, you will complete a PAINAD." Hand written beside this stated, "Full assessment, progress note every shift for seven days, and reassess via full assessment post seven days."

"You will complete the Pain Flow Record pre and post medication or nonpharmacological treatment.

Go to progress note and under tab do Pain Flow Note, complete all sections and effectiveness of intervention.

If you are using a medical directive it can only be used for 48 hours and then the physician must be notified if pain persists and not control for regular scheduled medications."

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to the improper care of resident #002.

Review of the CIS noted resident #002 had a witnessed fall on a specified date. The CIS noted after the fall pain assessments where not completed for resident #002.

Review of resident #002's documentation in Point of Care noted Personal Support Workers had documented the resident was experiencing pain on two separate occasions after resident #002's fall.

Review of resident #002's progress notes noted on four consecutive days after resident #002's fall, the resident displayed behaviours of new and increasing pain. Resident #002 was seen by the physician on the fourth day post fall and analgesia was ordered as needed for the resident's pain.

Review of resident #002's electronic Medication Administration Record noted resident #002 received analgesia as needed six times over a two day period.

A review of resident #002's electronic clinical record in PCC noted there were no Pain Flow Notes completed on resident #002 when there was indication they had pain and pre and post medication and nonpharmacological treatment. A Pain Flow Note was not completed on resident #002 until six days post fall.

In an interview, Registered Nurse (RN) #108 stated that pain assessments were completed on residents if they had new pain or they were started on new pain medication to see if the medication was effective. RN #108 stated staff would do a Pain Assessment in Advanced Dementia (PAINAD) and complete a Pain Flow Note and pain assessment if they needed to.

Further review of resident #002's progress notes in PCC indicated that the resident's physician was not contacted until three days after resident #002 started to experience pain.

In an interview, Registered Practical Nurse (RPN) #104 stated if a resident's pain was short term and subsided they would not contact the physician, but if it continued they would address it with the doctor and it would depend on the severity.

In an interview, RPN #109 stated they would call the physician when a resident was having pain and medical directive analgesia and non-pharmacological treatments were not helping relieve a resident's pain. RPN #109 stated when they came on shift four days after resident #002's fall, nothing had been done for resident #002. RPN #109 stated that the physician was called regarding resident #002's pain four days after resident #002's fall.

In an interview, Program Manager #103 stated registered staff called the physician when they returned to work four days after resident #002's fall, and reviewed resident #002's progress notes which indicated the resident was experiencing pain.

In an interview, Resident Assessment Instrument Coordinator (RAI-C) #101 stated they were the Pain and Palliation Lead and had created a binder based on policies, so staff had a guideline of what needed to be done if a resident was experiencing pain. RAI-C #101 stated when resident #002 was experiencing pain, staff should have followed the guidelines for "What if someone has pain or has started a new pain med?"

In an interview, Administrator/ Director of Care (DOC) #100 stated if a resident indicated they had pain, a pain assessment should be completed and then staff should write a Pain Flow Note. The Pain Flow Note had triggered questions - severity, description, location, provoking factors, action and response. Administrator/ DOC #100 stated any time a resident had pain this was the note staff should use. A Pain Flow Record was completed for monitoring if as needed medication was effective or not. Administrator/ DOC #100 stated if a resident started a new analgesic a Pain Flow Note was completed for 72 hours to monitor the effectiveness of the medication.

Administrator/DOC #100 stated resident #002 should have had a pain flow note completed when the resident started to experience pain and with the start of pain medication. Administrator/DOC #100 stated there might be some confusion with staff

regarding the pharmacy pre and post medication administration note, and the Pain Flow Note as staff were answering similar questions in each of those notes.

Administrator/DOC #100 stated staff should have contacted resident #002's physician when it was noted that resident #002 was experiencing pain.

The licensee has failed to ensure that the home's "Pain Identification and Management" policy was complied with, when resident #002 experienced pain and registered staff did not complete Pain Flow Notes for the new pain and the initiation of an analgesic and registered staff did not call resident #002's physician.

B) Review of resident #003's electronic clinical record noted resident #003 received two medications for pain control.

i) On a specific date, resident #003 was ordered an increase in one of their medications for pain control.

Review of resident #003's progress notes noted no documented Pain Flow Notes related to the effectiveness of the increase in pain control medication.

In an interview, Administrator/ Director of Care (DOC) #100 stated when a new analgesic was started a Pain Flow Note was completed for 72 hours to monitor the effectiveness of the medication and then if it was not effective staff would go back to the doctor. Administrator/DOC #100 reviewed resident #003's electronic clinical record and stated that resident #003 should have had Pain Flow Notes completed when the resident had an increase in their medication for pain control.

ii) Review of resident #003's electronic Medication Administration Record (EMAR) for the administration of medical directives during a two month time period, noted as needed analgesic was administered to resident #003 regularly during a three week time period.

The medical directive noted that the as needed analgesic could be administered "every 4 hours as needed for pain x 48 hrs for 2 Day… if pain becomes more intense or persists, and fever continues call physician."

Review of resident #003's electronic clinical record noted no documented evidence that the physician was notified when resident #003 had been administered as needed analgesic 17 times, over a three week period, with 10 out of 17 pain levels noted as a

seven to nine.

Further review of resident #003's electronic progress notes noted Pain Flow Notes were only documented on five occasions.

In an interview, Registered Practical Nurse (RPN) #104 stated if a resident's pain was short term and subsided they would not contact the physician, but if it continued they would address it with the doctor and it would depend on the severity.

In an interview, RPN #109 stated they would call the physician when a resident was having pain and medical directive analgesic and non-pharmacological treatments were not helping relieve a resident's pain.

In an interview, RPN #110 stated pain assessments were completed quarterly, and with any new signs and symptoms of pain. RPN #110 stated they would do a Pain Assessment in Advanced Dementia (PAINAD) pain flow note for five days then look back at all the pain flow notes and complete a full assessment.

In an interview, Registered Nurse #108 stated if a resident was having pain they would complete a Pain Flow Note and then a full pain assessment if they need to. RN #108 stated pain assessments were completed quarterly and if a resident was having new pain.

In an interview, Administrator/ Director of Care (DOC) #100 stated the Pain Flow Note had triggered questions - severity, description, location and provoking factors, action and response. Administrator/DOC #100 stated that any time a resident had pain staff should complete a pain flow note. Administrator/DOC #100 stated the physician should have been notified of the regular use of medical directive analgesia for resident #003's pain.

The licensee has failed to ensure that the home's "Pain Identification and Management" policy was complied with when Pain Flow Notes were not completed for resident #003 when they had an increase in pain, an increase in the dosage of medication for pain control and use of medical directive analgesic and resident #003's physician was not contacted. [s. 8. (1) (a), 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

Issued on this 5th day of September, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2019_725522_0012
Log No. / No de registre :	014708-19, 015108-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 4, 2019
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Port Stanley 4551 East Road, PORT STANLEY, ON, N5L-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lynsey McIntyre

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must comply with s. 52. (2) of Ontario Regulation 79/10.

Specifically, the licensee must ensure:

Resident #002, #003 and any other resident whose pain is not relieved by initial interventions, is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Grounds / Motifs :

1. The licensee has failed to ensure when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to the improper care of resident #002.

Review of the CIS noted resident #002 had a witnessed fall on a specified date. The CIS noted after the fall pain assessments where not completed for resident #002.

Review of resident #002's progress notes noted on four consecutive days after resident #002's fall, the resident displayed behaviours of new and increasing pain. Resident #002 was seen by the physician on the fourth day post fall and analgesia was ordered as needed for the resident's pain.

Review of resident #002's electronic clinical record in Point Click Care (PCC)

noted the resident had not received a pain assessment until six days post fall.

In an interview, Registered Practical Nurse (RPN) #104 stated that a pain assessment would be completed on a resident who had new pain. RPN #104 stated if a resident was cognitively impaired they would look at their body language to determine if they were in pain and the home used the PAINAD tool for cognitively impaired residents to determine their level of pain.

RPN #104 stated that they had provided care to resident #002 after the resident's fall. RPN #104 stated that resident #002 had declined on their shift and the resident posed challenges to provide care, tried to strike out at staff and refused to be repositioned. RPN #104 stated they were thorough with inspecting the resident for injury and it was not new for the resident to display behaviours. RPN #104 stated they could tell resident #002 was having some discomfort and they did apply a rub on the resident's back. RPN #104 stated that they had not completed a pain assessment on the resident at that time.

In an interview, Personal Support Worker (PSW) #107 stated they had provided care to resident #002 after their fall. PSW #107 stated that they had noted a change in resident #002's behaviours after their fall. PSW #107 stated resident #002 was in pain and they had reported it to the Charge Nurse.

In an interview, Program Manager (PM) #103 and RAI Coordinator (RAI-C) #101 stated that staff had not completed a pain assessment on resident #002 when they continued to have a change in behaviours and remained in bed after their fall.

PM #103 and RAI-C #101 stated when they spoke with staff regarding not completing a pain assessment for resident #002 after their fall, staff had indicated they assumed resident #002 was displaying behaviours which was not unusual for the resident. PM #103 stated staff did not think the change in the resident's behaviours was related to pain.

In an interview, Administrator/Director of Care #100 stated that staff should have completed a pain assessment on resident #002 when the resident continued to display signs of increased pain after their fall.

(522)

2. Review of resident #003's electronic clinical record noted resident #003 received two medications for pain control.

On a specific date, resident #003 was ordered an increase in one of their medications for pain control.

Review of resident #003's electronic Medication Administration Record (EMAR) for the administration of medical directives during a two month time period, noted as needed analgesic was administered to resident #003 regularly during a three week time period.

Review of resident #003's pain assessments in Point Click Care (PCC) noted no documented evidence that a pain assessment was completed when resident #003 had their medication for pain control increased or when resident #003 was regularly using medical directive analgesic.

In an interview, RPN #110 stated pain assessments were completed quarterly, and with any new signs and symptoms of pain. RPN #110 stated they would complete a Pain Assessment in Advanced Dementia (PAINAD) or pain flow note for five days then look back at all the pain flow notes and complete a full assessment.

In an interview, Registered Nurse #108 stated if a resident was having pain they would complete a Pain Flow Note and then a full pain assessment if they need to. RN #108 stated pain assessments were completed quarterly and if a resident was having new pain. RN #108 stated they would also do a pain assessment if a resident started a new pain medication to see if the medication was effective.

In an interview, Administrator/Director of Care (DOC) #100 reviewed resident #003's clinical record with inspector. Administrator/DOC #100 stated resident #003 should have had a pain assessment completed with the increased use of medical directive analgesia. Administrator/DOC #100 stated medical directives did not show up on the eMAR with the routine medications, so if staff were coming on shift they would not always know a resident was given analgesia from the medical directive. Administrator/DOC #100 also stated resident #003 should

have had a pain assessment completed within 72 hours of the increase in medication for pain control.

The licensee has failed to ensure when resident #002 and #003's pain was not relieved by initial interventions, resident #002 and #003 were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. (522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

Service Area Office /
Bureau régional de services : London Service Area Office