Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
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Original Public Report

Report Issue Date: March 19, 2024
Inspection Number: 2024-1289-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Pleasant Manor Retirement Village
Long Term Care Home and City: Pleasant Manor Retirement Village, Virgil

Lead Inspector	**Inspector Digital Signature**
Nishy Francis (740873)	Nishy Francis Digitally signed by Nishy Francis Date: 2024.03.25 14:34:33 -04'00'

Additional Inspector(s)
Stephany Kulis (000766)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20 - 23, 26 - 29, 2024

The following intake(s) were inspected:

- Intake: #00109245 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management

Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee failed to ensure resident was afforded privacy in treatment and in caring for their personal needs.

Rationale and Summary
A resident's room overlooked a neighboring property where the backyard, patio,

and windows of someone's home was seen. The blinds in the resident's room were not in good working order, staff were unable to close the blinds. The resident stated they can see outside when care is provided. The Assistant Director of Care (ADOC) stated that not closing the blinds is an invasion of the resident's privacy.

The resident's privacy was put at risk when not being able to ensure windows were closed when providing care.

An alternative for was offered to give resident privacy while awaiting replacement.

Sources: Observations of resident room; interviews with resident and ADOC. [000766]

Date Remedy Implemented: February 28, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure the written plan of care provided clear directions to staff regarding the level of assistance required for a resident.

Rationale and Summary
According to a resident's care plan they required a specified level of care. A PSW acknowledged the directions to provide direct care to the resident were unclear. The ADOC stated they had updated the care plan to match the specified level of

care but before it did not align.

The care plan was amended following the review of the resident's clinical records and was consistent with the current tasks in place.

Sources: Interviews with ADOC; and resident's clinical records. [000766]

Date Remedy Implemented: February 22, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (d)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(d) an explanation of the duty under section 28 to make mandatory reports;

The licensee has failed to ensure that an explanation of the duty under section 28 to make mandatory reports was posted in the home.

Rationale and Summary
The explanation of the duty under section 28 to make mandatory reports was not posted in the home. The ADOC acknowledged the document was not posted.

On February 28, 2024, duty under section 28 to make mandatory reports was posted in the home.

Sources: Observations; review of the Family and Resident Information Binder; and interview with ADOC.
[000766]

Date Remedy Implemented: February 28, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (f)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints;

The licensee has failed to ensure that the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints was posted in the home.

Rationale and Summary
The written procedure, provided by the Director, for making complaints to the Director was not posted in the home. The ADOC acknowledged the document was not posted.

The written procedure, provided by the Director was posted in the home the same day.

Sources: Observations; review of the Family and Resident Information Binder; and interview with ADOC. [000766]
Date Remedy Implemented: February 20, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.

Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home.

Rationale and Summary
The explanation of the current version of the visitor policy was not posted in the home. The ADOC acknowledged the document was not posted.

On February 28, 2024, the current visitor policy was posted in the home.

Sources: Observations; review of the Family and Resident Information Binder; and interview with ADOC. [000766]

Date Remedy Implemented: February 28, 2024

WRITTEN NOTIFICATION: Plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A) The licensee has failed to ensure that the care was provided to a resident as specified in the plan of care.

Rationale and Summary
During dining service observation, a resident was served a diet texture different to the plan of care. A dietary aide acknowledged the resident's diet texture was changed. On a specified date, the resident could return to their previous diet. The resident's diet texture was not updated, and they continued to receive a different diet texture. The Nutrition manager stated that changes to residents' diet were communicated by registered staff to the dietary staff and recorded in a communication book. The communication book was not updated. In a follow up observation on a specified date, the communication book was updated to inform staff that the resident was to resume their original texture. The Nutrition manager and the Registered Dietitian (RD) confirmed the resident was not provided the diet texture as per their plan of care.

When the resident was not provided the diet texture as per their care plan, there was risk of chewing difficulties.

Sources: Observation on February 20 and 21, 2024; Interview with staff; Record review of resident's care plan and Dietary staff communication book [740873].

B) The licensee failed to ensure the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
A resident's care plan states that the resident requires assistance by two staff for care. On a specific date, a PSW was observed providing care without a second staff member. The PSW stated they were aware the care plan states the resident requires assistance by two staff. The ADOC stated the expectation for staff is to provide care as outlined in the resident's plan of care.

The resident was put at risk for falls or injury when the staff did not follow the level of assistance required set out in the plan of care.

Sources: Resident's clinical records; observations; and interviews with PSW and ADOC. [000766]

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure the provision of the care set out in the resident's plan of care was documented.

Rationale and Summary
A resident's Documentation Survey had missing documentation for activities of daily living across multiple shifts over the month. The resident stated they do recall receiving care on days specified in their plan. The ADOC stated there is incomplete documentation and the expectation for staff is to document when care is completed.

Staff failing to document when and how the provision of care was provided could have delayed the indication of changes with the resident.

Sources: Resident's clinical records; interviews with resident and ADOC. [000766]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 43 (1)

Resident and Family/Caregiver Experience Survey

s. 43 (1) Every licensee of a long-term care home shall ensure that, unless otherwise directed by the Minister, at least once in every year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

The licensee failed to ensure that in 2023 a survey was taken of the families and caregivers of the residents to measure their experience with the home and the care, services, programs and goods provided at the home.

Rationale and Summary

The Administrator acknowledged the family/caregiver experience survey for the year 2023 was not conducted, and only results from residents were obtained.

Sources: Resident Satisfaction Survey for 2022 and 2023; interview with the Administrator. [740873]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 43 (5) (b)

Resident and Family/Caregiver Experience Survey

s. 43 (5) The licensee shall ensure that,

(b) the actions taken to improve the long-term care home, and the care, services,

programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any.

The licensee has failed to ensure that the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the resident experience survey were documented.

Rationale and Summary
The results of the resident experience survey conducted by the home in 2022 indicated resident comments pertaining to dietary services and recreation services. Review of the home's Continuous Quality Improvement Initiative Report dated August 2023, did not include any actions taken to improve the dietary and recreational services based on the feedback from the survey. The Administrator, the home's designated lead for the home's CQI initiative, acknowledged that the CQI committee addressed the comments with the Resident's Council during a meeting but did not capture the actions in the CQI report.

When actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the resident experience survey are not documented, there is risk that resident feedback is not addressed and included in quality improvement initiatives.

Sources: Review of the CQI report for 2023, 2022 Resident Experience Survey; interview with the Administrator. [740873]

WRITTEN NOTIFICATION: Family Council

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (a)
Family Council

s. 65 (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and

The licensee failed to ensure the obligation of when the home has no Family Council, that on an ongoing basis there was advisement to residents' families and persons of importance to residents of the right to establish a Family Council.

Rationale and Summary
Review of the minutes of the Family Council meeting dated May 17, 2023 indicated no further Family Council meetings were held after that date. Review of electronic newsletters sent to residents' families and persons of importance did not advise them of the right to establish a Family Council after May 17, 2023. The interim Therapeutic Recreation Supervisor confirmed they had not sent communication to resident's families of the right to establish a Family Council. A former member of the family council stated they had not received communication on the right to establish a family council. The administrator confirmed that residents' families and persons of importance to residents were not advised on an ongoing basis of the right to establish a Family Council. Observations of the home and interview with the Administrator confirmed there were no postings regarding the right for establishment of a Family Council in the home. The Administrator confirmed that ongoing advisement to residents' families and persons of importance to residents of the right to establish a Family Council was not provided through other avenues.

There is potential risk that residents' families and persons of importance to residents were not provided the opportunity to collaborate on forming a family council when the home did not advise them on an ongoing basis of the right to establish a Family Council.

Sources: observations of home's bulletin board; record review of the home's newsletters; interviews with Administrator, interim Therapeutic Recreation Supervisor, and former member of Family Council. [740873]

WRITTEN NOTIFICATION: Family Council

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)
Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee failed to ensure the obligation when the home has no Family Council, that they convened semi-annual meetings in 2023 to advise the residents' families and persons of importance to residents of the right to establish a Family Council.

Rationale and Summary
The Administrator acknowledged the home did not convene semi-annual meetings in 2023 to advise the residents' families and persons of importance to residents of the right to establish a Family Council.

There was potential risk that families and persons of importance to the residents of the home may not have been aware of the right to establish a Family Council.

Sources: May 2023 meeting minutes; interview with the Administrator. [740873]

WRITTEN NOTIFICATION: Dining and snack service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that during the lunch meal service, residents were served food and fluids at a temperature that is both safe and palatable.

Rationale and Summary

During a lunch meal service observation on February 20, 2024, inspector observed that prior to serving lunch to residents the temperature of food being served was not recorded. A dietary Aide confirmed food temperatures were not recorded prior to the meal service, and they were aware food temperatures should be checked and recorded prior to serving the residents. The Nutrition Manager verified that prior to a meal service, food temperatures were to be recorded to ensure safe food temperatures were maintained. The home's policy titled Recording and taking Food Temperatures stated serving temperatures of all food offered in a meal service were to be checked and recorded.

When the home failed to record temperatures of food offered in a meal service, there is a risk that safe food handling temperatures have not been maintained.

During a follow up lunch meal observation in the dining room on February 21, 2024, inspector observed that food and fluid temperatures were recorded prior to the meal service.

Sources: Observations on February 20 and 21, 2024; Interview with Dietary Aide and the Nutrition Manager; review of the home's manual titled Taking and Recording

Food Temperatures, last revised January 2024, and review of Food Temperature Record for February 20 and 21, 2024. [740873]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).
The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 11.6 that Additional Screening Requirements were to be followed in the home which included appropriate screening signage.

There was no signage at entrances and throughout the home that listed the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual. IPAC Lead stated they were aware of the required signage to be posted in the home and confirmed it was not posted.

Failing to post appropriate screening signage with self-monitoring procedures within the home put residents at risk for spread of infectious diseases.

Sources: Observations and interview with IPAC Lead; IPAC Standard for Long-Term

Care Homes April 2022 and Revised September 2023. [000766]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 3.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
3. Overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.

The licensee failed to ensure the IPAC Lead carried out the responsibility of overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.

Rationale and Summary
Part of the IPAC Lead's key responsibilities was to manage and oversee the IPAC program and delivery of its education to all staff, caregivers, volunteers, visitors, and residents. IPAC Lead stated all IPAC training was created prior to their employment and they did not have access to the content. Employees completed annual training online and only Human Resources has access to the employee training records. IPAC lead acknowledged they could not access the content of IPAC education delivered to staff and was unable to track the completion of all required training on orientation and on an annual basis. IPAC lead was unable to oversee the delivery of IPAC education to all staff. IPAC Lead stated they provide on the spot training and education during audits. The Director of Clinical Services (DCS) stated they provide majority of the IPAC education in the home and identified a gap between who

formally provides the training and tracking.

Residents were at risk for possible spread of infectious disease when the IPAC Lead failed to oversee full and comprehensive education given to all staff, caregivers, volunteers, visitors and residents.

Sources: IPAC Lead Job Description; and interviews with IPAC Lead and DCS. [000766]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
5. The home's registered dietitian.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee was composed of the home's registered dietitian (RD).

Rationale and Summary
The Administrator, the home's designated lead for the home's CQI initiative, acknowledged that the CQI committee did not include the home's RD. The minutes of the meeting did not include the home's RD in attendance and in the regrets. The RD confirmed they were not invited to participate in the home's CQI committee.

By failing to include the home's RD on the CQI committee, the opportunity for the RD to contribute on the licensee's CQI initiative was lost.

Sources: Review of the CQI meeting minutes for January 30, 2024; interview with the Administrator and the RD. [740873]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure the continuous quality improvement (CQI) report

required under Ontario Regulation 246/22 s. 168 (1) included a written record of all the required information.

Rationale and Summary
A review of the home's website included their 2023 CQI report. Review of the 2023 CQI report revealed that not all the above-mentioned required information, was included in the report. The Administrator, the home's designated lead for the home's CQI initiative, acknowledged the required information was not included in the CQI report.

There was minimal risk to residents when the licensee failed to ensure that the above-mentioned information was included in the CQI report.

Sources: Review of the CQI report for 2023; interview with the Administrator. [740873]

WRITTEN NOTIFICATION: Orientation

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(c) signs and symptoms of infectious diseases;
The licensee has failed to ensure the training that was provided for staff in regards to IPAC included signs and symptoms of infectious diseases.

Rationale and Summary
A review of the annual IPAC education provided to staff did not include signs and symptoms of infectious diseases. A Registered Practical Nurse (RPN) stated they did

not receive training on signs and symptoms of infectious diseases. The DCS confirmed signs and symptoms of infectious diseases was not included in the annual training.

When signs and symptoms of infectious diseases was not included in the required IPAC education, residents were at increased risk of infection transmission due to the possibility of the education not being provided in full, as required.

Sources: IPAC education on Systems 24/7; interviews with DCS and RPN. [000766]

WRITTEN NOTIFICATION: Orientation

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(e) what to do if experiencing symptoms of infectious disease;

The licensee has failed to ensure the training that was provided for staff in regards to Infection Prevention and Control (IPAC) included what to do if experiencing symptoms of infectious disease.

Rationale and Summary
A review of the annual IPAC education provided to staff did not include what to do if experiencing symptoms of infectious disease. An RPN stated they did not receive training on what to do if experiencing symptoms of infectious disease. The DCS confirmed what to do if experiencing symptoms of infectious disease was not included in the annual training.

When what to do if experiencing symptoms of infectious disease was not included in the required IPAC education, residents were at increased risk of infection transmission due to the possibility of the education not being provided in full, as required.

Sources: IPAC education on Systems 24/7; and interviews with DCS and RPN. [000766]

WRITTEN NOTIFICATION: Orientation

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee has failed to ensure the training that was provided for staff in regards to IPAC included handling and disposing of biological and clinical waste including used personal protective equipment.

Rationale and Summary
A review of the annual IPAC education provided to staff did not include signs and symptoms of infectious diseases. An RPN stated they did not receive training on handling and disposing of biological and clinical waste including used personal protective equipment. The DCS confirmed handling and disposing of biological and clinical waste including used personal protective equipment was not included in the annual training.

When handling and disposing of biological and clinical waste including used personal protective equipment was not included in the required IPAC education, residents were at increased risk of infection transmission due to the possibility of the education not being provided in full, as required.

Sources: IPAC education on Systems 24/7; interviews with DCS and RPN. [000766]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee has failed to ensure that all staff who provide direct care to residents receive training on the required program for skin and wound care in 2023.

Rationale and Summary
The DCS and Administrator stated skin and wound care training for all staff who provide direct care to residents was offered during on site in-services throughout the year 2023. They acknowledged all direct care staff had not attended the in services.

The home could not provide training records for all direct care staff on skin and wound care for 2023.

When the home failed to provide training on the required program for skin and wound care to all staff who provide direct care to residents, there is potential risk that staff are not familiar with the home's skin and wound program.

Sources: Interview with the Administrator and DCS. [740873]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain.

The licensee has failed to ensure that all staff who provided direct care to residents received training on the required program for pain management in 2023.

Rationale and Summary
The DCS and Administrator stated pain management training for all staff who provide direct care to residents was offered during on site in-services throughout the year 2023. They acknowledged all direct care staff had not attended the in services.

The home could not provide completed training records for the year 2023 for all direct care staff on pain management.

When the home failed to provide training on the required program for pain management to all staff who provided direct care to residents, there is potential risk

that staff are not familiar with the home's pain management program.

Sources: Interview with the Administrator and DCS. [740873]