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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 9, 2023
Original Report Issue Date: August 2, 2023
Inspection Number: 2023-1559-0002 (A1)
Inspection Type: Complaint Follow up Critical Incident System
Licensee: Regional Municipality of Durham
Long Term Care Home and City: Hillsdale Estates,Oshawa

Amended By	**Inspector who Amended Digital Signature**
Sami Jarour (570)	Sami Jarour Digitally signed by Sami Jarour Date: 2023.08.09 15:21:34 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Adjust the CDD at the request of the home for CO #001 and CO #002 to September 25, 2023.

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Lead Inspector Sami Jarour (570)	**Additional Inspector(s)** Reethamol Sebastian (741747) Rexel Cacayurin (741749)
Amended By Sami Jarour (570)	**Inspector who Amended Digital Signature** Sami Jarour Digitally signed by Sami Jarour Date: 2023.08.09 15:21:54 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Adjust the CDD at the request of the home for CO #001 and CO #002 to September 25, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19-23, 26, 27, 29, 30, 2023 and July 4-7, 2023
The inspection occurred offsite on the following date(s): July 5, 2023

The following intake(s) were inspected:

- Intake: #00084459 - Follow-up to Compliance Order #001 related to nutritional care and hydration

programs.
• Intake: #00019850 - complaint related to falls, skin and wound, medication administration and missing personal items.
• Intake: #00016380 - complaint related to neglect, wound care, plan of care, bathing, and lack of communication with the home,
• Intake: #00089796 - complaint related to dehydration and care concerns.
• Intake: #00022857 - complaint related to diet and available food choices.
• Intake: #00020055 - complaint related to diabetes monitor sensor missing.
• Intake: #00016397 - CI related to an allegation of neglect.
• Intake: #00014419 - CI related to an allegation of neglect.
• Intake: #00088984 - CI related to a fall incident.
• Intake: #00002673 - CI related to an allegation of staff to resident abuse.
• Intake: #00084228 - CI related to an allegation of resident to resident abuse.
• Intake: #00002397 - CI related to an allegation of resident to resident abuse.
• Intake: #00089570 - CI related to an allegation of resident to resident abuse.
• Intake: #00089595 - CI related to a medication incident.

The following intake(s) were reviewed during this inspection:
•Intake: #00001339 - CI, Intake: #00002042 - CI, Intake: #00002162 - CI, Intake: #00002465 - CI, Intake: #00002742 - CI, Intake: #00003861 - CI, Intake: #00005698 - CI, Intake: #00006313 - CI, Intake: #00006424 - CI, Intake: #00006445 - CI, Intake: #00012583 - CI, Intake: #00014377 - CI, Intake: #00087813 - CI, Intake: #00087561 - CI, Intake: #00087035 - CI and Intake: #00086130 - CI related to falls incidents.

•Intake: #00085912 - CI, Intake: #00021537 - CI, Intake: #00006728 - CI, Intake: #00020101 - CI, Intake: #00021189 - CI, Intake: #00085891 - CI, Intake: #00085369 - CI, Intake: #00017635 - CI, Intake: #00017611 - CI and Intake: #00002309 - CI related to responsive behaviours.

•Intake: #00016540 - CI related to a medication incident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1559-0001 related to O. Reg. 246/22, s. 74 (2) (d) inspected by Reethamol Sebastian (741747)

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

Resident Care and Support Services

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care was provided to residents as per the plan of care.

Rationale and summary

1. A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to concerns with a resident's wound care and morning care. The complaint indicated that the substitute decision-maker (SDM) complained to Registered Practice Nurse (RPN) that the resident did not receive wound care and morning care until an identified time.

The written plan of care indicated the resident's preference was to have morning care within an identified time frame. The complainant alleged due to morning care and wound care not being completed on time, the resident missed lunch.

An interview with Personal Support Worker (PSW) #115 confirmed they usually give care around a specified time; however, they were short staffed on weekends, and the resident was up after the specified time. PSW #125 indicated it depended on who was working the shift and when the resident received morning care.

When morning care was not provided during the resident's identified preferred time, this caused

mistrust and frustration for the resident and their family.

Sources: Resident clinical records, interview with the resident, PSW #115, PSW #125, RPN #116 and Assistant Administrator #126. [741747]

2. A Critical Incident System (CIS) was received by the Director related to an alleged staff to resident physical abuse incident.

The home's internal investigation records indicated that PSW #119 failed to adhere to a resident's plan of care when staff provided personal care with one person when the resident's plan of care indicated they required two people to complete the care.

A review of the resident's written plan of care and progress notes indicated the resident required extensive assistance from two staff members for care. The Director of Care (DOC) confirmed that PSW #119 did not follow the plan of care for the resident, which required two people's assistance for care.

When the plan of care for the resident was not followed for care, it placed the resident at risk for injury.

Sources: CIS report, resident's clinical records, licensee's internal investigation records, and interview with DOC. [741747]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that they had immediately forwarded to the Director any written complaint that was received concerning the care of a resident.

Rationale and Summary

A complaint was forwarded to the MLTC from the Patients Ombudsman related to care concerns brought forward related to a resident. The complainant indicated an email letter was sent to the LTC home with multiple concerns. The complainant indicated that they did not receive any written response from the LTC home and that they had to search for the Patient Ombudsman's contact information to voice their concerns. The complainant indicated they had a meeting with the LTC home in response to the email letter.

The Director of Care (DOC) indicated they received the email from the resident's substitute decision-maker (SDM) on a specified date and arranged a meeting to discuss the family's concerns. The DOC acknowledged the email letter included care concerns that should have been dealt with as a written complaint was not forwarded to the Director.

Failure to immediately forward written complaints to the Director concerning the care of a resident or the operation of a long-term care home puts residents at increased risk of harm and delays action from the Director.

Sources: Email from SDM of a resident and interview with DOC. [570]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee failed to ensure that the report to the Director included the results of the investigation and every action taken for an alleged staff to resident neglect involving a resident.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director related to an allegation of staff to resident neglect involving a resident by RPN #132 and RN #133. The report to the Director was not amended to include the results of the investigation.

A review of the licensee's investigation notes, and disciplinary actions taken, indicated the licensee concluded that on a specified date, RPN #132 and RN #133 neglected to provide care to the resident in a timely manner.

The Assistant Director of Care (ADOC) #112 indicated the investigation was concluded on a specified date, and disciplinary actions were taken for RPN #132 and RN #133 and both no longer work for the licensee. The ADOC confirmed they did not amend the report to the Director with the results of the investigation.

Failing to provide the results of the investigation to the Director resulted in the Director not being aware that the allegation was founded, preventing the Director from responding as required.

Sources: CIS report, review of the licensee's investigation notes and interview with the Assistant Director of Care (ADOC) #112. [570]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

The licensee has failed to comply with their nutrition and hydration program to ensure that interventions to mitigate and manage risks for a resident, were implemented.

In accordance with Ontario Regulation 246/22, s.11. (1) b, the licensee was required to ensure that any plan, policy, protocol, program, procedure, strategy, initiative or system was complied with.

Specifically, the policy "Provisions of Fluids" was not complied with.

Rationale and Summary

A complaint was received expressing concerns related to a resident sent to the hospital and diagnosed with dehydration and sepsis.

The home's policy titled "Provision of Fluids" indicated members of the health care team will monitor residents' hydration status as part of their routine assessment. Registered staff will complete the "Dehydration Risk Assessment Tool" if fluid intake is poor and/or any signs or symptoms of dehydration are present. Note: poor fluid intake is defined by three consecutive days of fluid intake less than 1000ml or 6 servings of 175ml which is considered a change from the usual intake pattern.

The resident's nutritional care plan indicated they were at moderate nutritional risk and required 1525ml daily to meet 100% of their estimated fluid requirements.

A review of the resident's fluid intakes for a specified month indicated the resident had not met their daily fluid goal and consumed less than 1000ml on three consecutive days.

RPN #136 and RD #104 acknowledged that the resident's fluid intake was below 1000ml on three consecutive days and indicated that a dehydration risk assessment was not completed.

The Manager of Nursing Practice (MNP) #137 indicated that a dehydration risk assessment should have been completed as per policy “provisions of fluids".

Failure to follow the "Provisions of Fluids" policy puts residents at risk of dehydration.

Sources: Resident’s clinical records; PCC Look Back Report; the licensee’s Provisions of Fluids, and interviews with RPN #136, RD #104 and MNP #137. [570]

WRITTEN NOTIFICATION: ACCOMMODATION SERVICES

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (iv)

The licensee has failed to ensure that the process of locating residents’ lost clothing and personal items is implemented.

Rationale and summary

A complaint was submitted to the MLTC related to concerns related to a resident's missing clothing. The complaint indicated the resident’s entire wardrobe was missing, and the resident’s closet was full of other people's clothes. The resident’s family member keeps the resident's clothes at home and brings them every day.

Progress notes on specified dates indicated that the resident's Substitute Decision-Maker (SDM) was visibly upset that the resident had no clothing and can’t afford to buy more clothes. The SDM signed the resident missing belongings form, however, no updates had been provided by the home.

The home's procedure for Resident Missing Belongings Reporting & Follow-up procedure says, upon return of all forms to the resident care coordinator (RCC), the resident and/or family will be informed of the search outcome by the appropriate department head as determined by the RCC. After the resident/family has been contacted, the completed form(s) are sent to reception for tracking and filing. Forms for missing items not found will be kept by reception so that any found items can be compared against any items reported lost.

A review of the home’s items lost and found log indicated the missing items for the resident were not included in the log for resident's missing belonging digital or printed form.

In an interview, the Assistant Director of Care (ADOC) #112 confirmed that if the item is not found, the Resident Care Coordinator (RCC)/registered staff will contact the family. If the item is not found, the home will reimburse the cost of the item depending on the items lost on an individual basis. The missing item form process does say to keep a copy of the form, and they don't print it anymore as they have access to the digital version. The reception staff also gets the email.

Failure to ensure that the process of locating residents' lost clothing and personal items is implemented impacted the resident's dignity.

Sources: Resident's clinical records, the home's procedure for Resident Missing Belongings Reporting & Follow-up procedure, the home's items lost and found log and interview with ADOC#112. [741747]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored.

Rationale and summary

A complaint was received by the Director expressing concerns related to a resident who was sent to the hospital during an outbreak at the LTC home.

A review of progress notes for the resident indicated that on a specified date, the resident had presented a symptom and tested positive for COVID-19. The resident was placed on isolation precaution. The progress notes did not indicate that the resident's symptoms were monitored and recorded under infection/illness notes on three identified shifts.

The infection prevention and control (IPAC) lead #102 indicated a COVID-19 outbreak was declared in the home area where the resident resided; The resident was under enhanced precautions for COVID-19. The IPAC lead acknowledged that the documentation in the progress notes did not indicate that the resident's symptoms were monitored and recorded under infection/illness notes in three identified shifts.

Failure to monitor and record symptoms indicating the presence of infections every shift put residents at risk of not receiving timely interventions.

Sources: Resident's progress notes, the home's outbreak Line Listing, and an interview with IPAC Lead #102. [570]

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)

The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was notified of the result of an investigation of alleged neglect of a resident by staff.

Rationale and Summary

A Critical Incident System (CIS) report was submitted related to an allegation of staff to resident neglect involving a resident by RPN #132 and RN #133

A review of the licensee's investigation notes, and disciplinary actions taken, indicated the licensee concluded that on a specified date, RPN #132 and RN #133 neglected to provide care to a resident in a timely manner.

The Assistant Director of Care (ADOC) #112 indicated the investigation was concluded, disciplinary actions were taken and both RPN #132 and RN #133 no longer work for the licensee. The ADOC confirmed they did not notify the resident's SDM about the result of the investigation upon its completion.

Failing to provide the results of the investigation to the SDM prevented the SDM from taking further actions if needed.

Sources: CIS report, review of the licensee's investigation notes and interview with the Assistant Director of Care (ADOC) #112. [570]

WRITTEN NOTIFICATION: Reporting and Complaints

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

Non-compliance with: O. Reg. 246/22, s. 108 (2)

The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

Rationale and Summary

1. A complaint was received through the Patients Ombudsman related to care concerns brought forward related to a resident. The complainant indicated an email letter was sent to the home with multiple concerns. The complainant indicated they did not receive any written response from the LTC home and they had to search for the Patient Ombudsman's contact information to voice their concerns. The complainant indicated they had a meeting with the LTC home in response to the email letter.

A review of the home's records of complaints indicated the email letter related to care concerns brought forward by the SDM of a resident was not included in the home's complaints records.

The Director of Care (DOC) indicated they received the email from the substitute decision-maker (SDM) of a resident, and they arranged a meeting to discuss the family's concerns. The DOC acknowledged the email letter included care concerns that should have been dealt with as a written complaint, was not included in the home's complaint records.

Failure to document all verbal or written complaints prevents the home from effectively analyzing and improving the home's management of the complaints process.

Sources: Email from SDM of a resident, the LTCH complaints record, and interview with the DOC. [570]

2. The home received a verbal complaint from a resident's SDM regarding the care provided to the resident.

A review of the home's complaints binder revealed that a verbal complaint brought by a resident's SDM related to care provided to the resident was not included in the home's complaints records.

ADOC #112 confirmed that the home received the complaint from the resident's family, and the complaint binder was not updated about this complaint.

Failure to document all verbal or written complaints prevents the home from effectively analyzing and improving the home's management of the complaints process.

Sources: CIS report, Policy Management of Complaints, resident's care conference notes, the home's complaints binder, and interview with ADOC #112. [741747]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that pain medication was administered to a resident in accordance with the directions specified by the prescriber.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director related to a fall incident involving a resident. The CIS report indicated that the resident sustained a fall on a specified date. Two days after the fall, the resident complained of pain and was yelling out in pain during care. The resident was transferred to the hospital and diagnosed with an injury.

A review of the resident's progress notes indicated on a specified date and time, RPN #134 reported that the resident slept well through the night; no complaints or signs of pain post fall. RPN #134 reported the resident complained of pain in the side of their body and was yelling out in pain during care. The progress notes review did not indicate that as needed pain medication was administered to the resident when the resident presented with pain during care.

A review of the resident's medication administration record (MAR) for a specified month directed staff to give pain medication by mouth as needed for pain and fever. The pain medication was not given to the resident until more than four hours after the initial complaint of pain by the resident.

Resident Care Coordinator (RCC) #129 confirmed the resident had new pain during care that was reported to RPN #134. RCC #129 acknowledged that RPN #134 did not assess the resident for the new pain when it was reported to them. RPN #134 should have assessed the resident for pain and should have administered as needed pain medication.

Failure of staff to administer as needed pain medication to the resident as prescribed put the resident at risk of developing negative health outcomes.

Sources: CIS report, resident's medication administration record (MAR) and progress notes, and interview with Resident Care Coordinator (RCC) #129. [570]

(A1)
The following non-compliance(s) has been amended: NC #010

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1) Educate all registered staff in a specified residents' home area on the Residents' Bill of Rights, emphasizing rights #5 and #16. The education shall incorporate scenarios of neglect and ways to protect residents from neglect relating to providing care, services and treatments consistent with residents' assessed needs. A documented record must be kept of the education provided, who attended and who delivered the education. This record is to be made available to Inspectors immediately upon request.

2) Conduct audits in a specified residents' home area within 48 hours of each resident who falls, for a minimum of four week period from the receipt of this compliance order, to ensure residents who sustain falls are immediately assessed and actions taken with any change in condition post falls. The audit records must include who is conducting the audit, date, time, identify any deficiencies, the staff member responsible and the corrective action taken to ensure staff are aware of the deficiency. The audit records must be kept and made available to Inspectors immediately upon request.

Grounds
1. The licensee has failed to ensure that a resident was protected from abuse.

Section 2 of the Ontario Regulation 246/22 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director related to an allegation of abuse by a resident toward a co-resident. The CIS report indicated that staff witnessed a resident inappropriately touching a co-resident.

In an internal investigation document, Personal Support Worker (PSW) #111 indicated that they witnessed a resident inappropriately touching a co-resident. The two residents were immediately separated, and it was reported to RN #108.

Interviews with RN #108 and PSW #109 indicated that the resident was cognitively impaired and unaware of their action.

The BSO (Behavioural Support Ontario) lead, RN #108, PSW #111, and Director of Care (DOC), during separate interviews, each indicated that they considered the incident as abuse. They confirmed that the co-resident was incapable of giving consent.

Failure to protect the co-resident from abuse resulted in a risk to the resident's safety, dignity, quality of life and increased risk of further incidents.

Sources: CIS report, home's internal investigation documents, interviews with BSO lead, DOC, RN #108 and PSW #111 and PSW #109. [741749]

2. The licensee has failed to ensure that a resident was protected from abuse.

Rationale and Summary

A CIS report was submitted to the Director related to an allegation of abuse by a resident toward a co-resident. The CIR indicated that staff witnessed the resident inappropriately touching the co-resident.

In an internal investigation document, Personal Support Worker (PSW) #114 indicated that they witnessed a resident inappropriately touching a co-resident. PSW #114 moved the co-resident and reported to the charge nurse.

The BSO lead indicated that the resident had a history of targeting residents who were unable to defend themselves. They also confirmed that the co-resident was unable to defend themselves at the time of the incident.

The DOC, BSO lead, and PSW 114, during separate interviews, each confirmed that they considered the

incident as abuse. They also acknowledge that the co-resident was incapable of giving consent.

Failure to protect the co-resident from abuse resulted in a risk to the resident's safety, dignity, quality of life and increased risk of further incidents.

Sources: CIS report, home's internal investigation documents, interviews with BSO lead, DOC and PSW #114. [741749]

3. The licensee has failed to ensure that a resident was protected from abuse.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

A CIS report was submitted to the Director related to an allegation of abuse by a resident toward a co-resident. The CIR indicated that a resident punched a co-resident.

In an internal investigation note, PSW #138 indicated that the altercation between the involved residents started when the co-resident used derogatory words towards PSW #138. The resident defended the PSW and punched the co-resident with a closed fist.

The BSO lead, Assistant Director of Care (ADOC), RPN #117, during separate interviews, indicated that the residents had altercations in the past. They also acknowledged that the incident was considered as abuse. BSO lead also indicated that they assessed the co-resident and there was no further injury.

Failure to protect the co-resident resulted in moderate risk to the resident and increased risk for further injury.

Sources: CIS report, home's internal investigation documents, interviews with BSO lead, ADOC and RPN #117. [741749]

4. The Licensee has failed to ensure that the home protected a resident from neglect by RPN #132 and RN #133.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more

residents.

Rationale and Summary

Critical Incident System (CIS) reports related to a fall incident and allegation of neglect involving a resident were submitted to the Director. The CIS reports stated that the resident sustained a fall on a specified date and time. The following day, the resident was transferred to the hospital in poor condition and was diagnosed with an injury.

A review of health records for the resident indicated the resident was identified as at high risk for falls.

A review of the resident's progress notes indicated the resident sustained a fall on a specified date and time. The resident was assessed by RPN #130 with no injuries identified. A note was left in the doctor's book for further assessment. The following day, RPN #132 reported that the resident remained resistive and aggressive. The resident was unable to walk, had a swollen limb, and could not describe the pain. Facial grimacing was noted when the swollen limb was assessed and moved. Registered Nurse (RN) #133 and the Occupational Therapist (OT) were notified.

Nurse Practitioner (NP) #113 was called to assess the resident's specified limb which was not within a normal range of motion. The NP reported the resident presented with pain and was unable to respond to questions verbally. The resident had noted swelling and tenderness in a specified limb which was also tender, cold to touch, and appeared deformed. The resident received medication for pain and was transferred to the hospital to rule out an injury. On the following date, RN #133 reported the resident had a confirmed injury.

A review of the licensee’s investigation notes, and disciplinary actions taken indicated the licensee concluded that RPN #132 neglected to provide care to resident the resident in a timely manner despite recognizing behaviours and symptoms that were a significant deterioration in the resident’s health condition. The licensee concluded that RN #133 neglected to provide care to the resident during their shift and did not acknowledge critical health information reported to them. The resident was not assessed by RN #133 as part of their obligation as a Registered Nurse and decided that the physician did not need to see the resident, although there was a request on the physician’s round sheet to assess the resident due to an incident on the previous day.

The Assistant Director of Care (ADOC) #112 indicated they initiated an investigation to rule out neglect following the fall incident. The investigation was concluded and disciplinary actions were taken and both RPN #132 and RN #133 no longer work for the home. The ADOC further indicated the actions of both RPN #132 and RN #133 caused a delay in care for the resident, who was sent to the hospital in poor

condition.

Failure to ensure that a resident was assessed and provided care and treatment consistent with their needs resulted in delay in transferring the resident to the hospital in a timely manner, causing deterioration in the resident's health condition.

Sources: CIS reports, review of health records for the resident, review of the licensee's investigation notes and interview with the Assistant Director of Care (ADOC) #112. [570]

This order must be complied with by September 25, 2023

(A1)
The following non-compliance(s) has been amended: NC #011

COMPLIANCE ORDER CO #002 REQUIRED PROGRAMS

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Provide in-person education for all registered staff in two specified residents' home areas on the internal policy entitled "Pain Management,". Test the retention of this knowledge. A documented record must be kept and made available to Inspectors immediately upon request. The documented record must include the education that was provided, a copy of the retention test for each staff, and names of all staff educated, including date, time and who provided the education.

2) Conduct post falls audits for every resident fall in two specified residents' home areas for a minimum of four weeks from receiving this compliance order to ensure pain assessments were completed as required. Keep a documented record of any non-compliances identified and any actions taken, including the name of the staff person identified, who conducted the audits, date and time of the audits. The audit records must be kept and made available to Inspectors immediately upon request.

Grounds
1. The licensee has failed to ensure that the home's pain management program was followed, specifically where staff were required to complete a comprehensive pain assessment when a resident

had new pain.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee is required to ensure the home has in place a pain management program which includes assessment methods of residents, and that it must be complied with.

Specifically, staff did not comply with the "Pain Management" policy revised April 2021.

Rationale and Summary

Critical Incident System (CIS) reports were submitted to the Director related to a fall incident and an allegation of neglect of a resident. The CIS reports stated that the resident sustained a fall. The following day, the resident was transferred to the hospital and diagnosed with an injury. The resident passed away at the hospital,

A review of progress notes for the resident indicated a day after the fall incident, the resident was transferred into a chair by three staff, and the resident was unable to walk. RPN #132 reported the resident's specified limb was noted swollen, and the resident was unable to describe the pain and facial grimacing was noted when a specified limb was moved. RPN #132 administered PRN medication for pain. Later that day, Nurse Practitioner (NP) #113 reported the resident presented with pain and was unable to respond to questions verbally. The resident's specified limb was swollen, tender, cold to touch, and appeared deformed. The resident received medication for pain and was transferred to the hospital to rule out an injury. The progress note review did not indicate a comprehensive pain assessment was completed when the resident initially presented pain to RPN #132.

The home's Pain Management policy indicates each resident must be assessed for pain on admission and if triggered on readmission or and a significant condition change. The policy required staff to screen for pain on readmission, after change in clinical status, including post fall and to complete a comprehensive pain assessment when there is a change in status related to an increase in pain based on clinical judgement.

The Assistant Director of Care (ADOC) #112 confirmed the resident had new pain and that the comprehensive pain assessment was not completed.

Failure to perform a comprehensive pain assessment as per policy may have put the resident at risk of having unmanaged pain.

Sources: CIS reports, review of resident's progress notes, review of the licensee's Pain Management

Policy, and interview with the Assistant Director of Care (ADOC) #112. [570]

2. The licensee has failed to ensure that the home's pain prevention and management program was followed, specifically where staff were required to complete a comprehensive pain assessment when a resident had new pain.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee is required to ensure the home has in place a pain management program which includes assessment methods of residents, and that it must be complied with.
Specifically, staff did not comply with the "Pain Management" policy revised April 2021.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director related to a fall incident involving a resident. The CIS reports stated that the resident sustained a fall. Two days following the incident, the resident complained of pain in a specified area and was yelling out in pain during morning care. The resident was transferred to the hospital and diagnosed with an injury.

A review of progress notes for the resident indicated a comprehensive pain assessment was not completed when the resident complained of pain during morning care. Later that day, the physician assessed the resident, who complained of significant pain when attempting to move the resident's specified limb. The physician ordered an x-ray and discussed with the resident's SDM to transfer to the hospital to rule out an injury. On the same date, the resident was assessed by Nurse Practitioner (NP) #113. The resident had increased pain and was guarding a specified limb. The resident's SDM consented to hospital transfer for assessment. Four days later, the resident returned from the hospital and was diagnosed with an injury to a specified limb. A comprehensive pain assessment was initiated but not completed.

The home's Pain Management policy indicates each resident must be assessed for pain on admission and if triggered on readmission or and a significant condition change. The policy required staff to screen for pain on readmission, after change in clinical status including post fall and to complete a comprehensive pain assessment when there is a change in status related to an increase in pain based on clinical judgement.

The Resident Care Coordinator (RCC) #129 confirmed the resident had new pain during morning care which was reported to RPN #134. RCC #129 acknowledged that RPN #134 did not assess the resident for the new pain when it was reported to them. RPN #134 should have assessed the resident for pain using the comprehensive pain assessment tool, called the doctor if the pain scale was high, and administered

PRN pain medication.

Failure to perform a comprehensive pain assessment as per policy may have put the resident at risk of having unmanaged pain.

Sources: CIS report, resident's progress notes, the licensee's Pain Management Policy, and interview with Resident Care Coordinator (RCC) #129. [570]

This order must be complied with by September 25, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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