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

London District
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Original Public Report

Report Issue Date: October 29, 2024
Inspection Number: 2024-1137-0004
Inspection Type: Complaint
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
Long Term Care Home and City: Secord Trails Community, Ingersoll

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, 17, 2024
The inspection occurred offsite on the following date(s): October 23, 25, 28, 2024
The following intake(s) were inspected:

- Intake: #00121519 - A complaint related to palliative care
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The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Palliative Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcomes of the care set out in the plan of care were documented.

Rationale and Summary
A resident was receiving end of life care and passed away. Documentation of pain monitoring was not completed appropriately and there were no progress notes for over a 24 hour period of time prior to the resident's passing.

The Administrator and Director of Care stated they would expect that progress notes were documented related to the resident's condition and actions taken during end of life care. Staff would require clinical documentation at end of life to determine if reassessment and changes to the plan of care were needed to ensure the comfort of the resident.

Sources: Clinical health records for a resident and staff interviews.

WRITTEN NOTIFICATION: Palliative Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (3)
Palliative care
s. 61 (3) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other person or persons designated by the resident

or their substitute decision-maker are provided with an explanation of the palliative care options that are available based on the assessment of the resident's palliative care needs, which may include, but are not limited to, early palliative care and end-of-life care.

The licensee has failed to ensure that a resident's substitute decision-maker was provided with an explanation of the palliative care options that were available based on the assessment of the resident's palliative care needs including end-of-life care.

Rationale and Summary
A resident had declined, was deemed palliative, and end of life care was initiated, including pain medication ordered. The resident's family member was advised by registered nursing staff that they had run out of pain medication and requested that they administer the medication less frequently, so that it lasted longer.

Medication records showed that there was sufficient supply of medication available in the home. When the resident's family was advised that they were not able to administer pain medications as ordered, requested, or based on assessment, as there was not enough supply, they were not provided with an accurate explanation of the pain management options available, putting the resident at risk that they might not receive pain management as needed at end of life, as well as causing undo distress to the family.

Sources: Medication destruction records, emergency medication supply records, health records for a resident, staff interviews and interviews with a resident's family.