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 West District
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Original Public Report

Report Issue Date: December 8, 2023	
Inspection Number: 2023-1274-0008	
Inspection Type: Critical Incident Follow up	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Winston Park, Kitchener	
Lead Inspector Megan Brodhagen (000738)	**Inspector Digital Signature**
Additional Inspector(s) Kailee Bercowski (000734) Janet Groux (606)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 22-23, 2023, and November 28-30, 2023.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake #00097674 - related to resident injury with unknown cause.
- Intake #00098219 - related to an outbreak.
- Intake #00098757 - related to improper care of resident resulting in injury.

The following intake was completed in this Follow-Up inspection:

- Intake #00099814 - Follow-up to CO #001 of inspection #2023-1274-0007 with Compliance Due Date (CDD) of October 31, 2023, related to doors in the home.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1274-0007 related to O. Reg. 246/22, s. 12 (1) 3. inspected by Janet Groux (606)

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe

transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure safe transferring technique was used when a resident was transferred from their bed.

Rationale and Summary
A resident required total assistance for transfers.

Staff transferred the resident from their bed without using an assistive device.

Staff stated that during the transfer, the resident screamed and voiced pain.

Director Of Nursing Care (DOC) said staff transferred the resident improperly.

When staff do not follow safe transferring techniques, residents are at risk of injury.

Sources: Interviews with staff; Critical Incident Report # 2783-000020-23 and the resident's clinical records.
[000734]

WRITTEN NOTIFICATION: Pain management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee failed to comply with their pain management program's strategy to manage residents' pain, when they did not ensure action was taken to address a resident's pain.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee shall ensure that any actions taken with respect to a resident under a program, including relevant procedures, provides for methods to reduce risk and monitor outcomes, where required, and are complied with.

If a resident expresses pain, registered staff are to follow their Pain Management Program Policy (Nur 04-48), to reflect on care provided, and ensure action is taken to address resident’s pain.

Rationale and Summary
A resident expressed new and worsening pain. The physician instructed registered staff to notify them if the resident was experiencing further uncontrolled pain for consideration of an opioid.

Over the afternoon and evening on a specific day, the resident reported increased pain on two separate assessments after scheduled pain interventions were provided. It was noted that the resident was guarding and facial grimacing. No new strategies were implemented at these times.

DOC indicated that staff conversations with the physician should be documented in the progress notes. DOC reviewed the progress notes and said that there were no further conversations with the physician documented before the resident was sent to hospital.

When staff did not ensure action was taken to address the pain, the resident experienced a delay in effective treatment of their pain.

Sources: Interviews with staff; Schlegel Villages Pain Management Program Policy (Nur 04-48); Resident's clinical records.
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