Ontario

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

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection 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: June 1, 2023	
Original Report Issue Date: April 11, 2023	
Inspection Number: 2023-1012-0002 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.	
Long Term Care Home and City: Altamont Care Community,Scarborough	
Amended By Diane Brown (110)	**Director who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to: This report has been amended to: The compliance due date was changed from June 1, 2023 until July 1, 2023.

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Long Term Care Home and City: Altamont Care Community, Scarborough	
Lead Inspector Diane Brown (110)	**Additional Inspector(s)**
Amended By Diane Brown (110)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to: This report has been amended to: The compliance due date was changed from June 1, 2023 until July 1, 2023.

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 6 -10, 14-17, 22, 24, 27-28, March 1-3, 2023.

The following complaint(s) intake(s) were inspected:

- Intake: #00011570 - regarding infections, neglect, continence care, wound care, dehydration.
- Intake: #00018013 - regarding an injury of unknown cause and pain management.

The following critical incident(s) was inspected:

- Intake: #00018048 -related to resident to resident physical abuse.

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

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Pain 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 (1) (c)

The licensee failed to ensure that a resident's written plan of care sets out clear direction to staff and others who provide direct care to the resident.

Rationale and Summary

A complaint was received related to a resident's significant change in status and their subsequent care.

A resident had a witnessed medical incident. A registered practical nurse (RPN) #117 documented they obtained vital signs, notified the doctor, and was directed to monitor the resident frequently. There were no vital signs or monitoring of the resident, documented by RPN #117. The following shift, RPN #121 documented the resident complained of unrelieved pain to an identified area but no monitoring, or vitals were documented. The following day the resident's family visited, noted the resident had deteriorated, and requested the physician assess the resident.

An interview with the physician confirmed their expectation of monitoring the resident frequently, included checking the resident every two hours for any further medical incidents and to complete vital signs. The RPN #117 indicated the doctor's direction to monitor the resident frequently should have included hourly checks with vitals but could not recall whether they completed the resident's vitals on their shift. RPN #121 working later that same day, could also not recall if they completed the resident's vitals. The DOC identified that each nurse's professional judgement could vary on how often vitals should be monitored but not taking or recording vitals from the time of the resident's incident for six days was not considered monitoring of the resident. A review of the resident's clinical record revealed no documented monitoring including vital signs, of the resident, for six days following the resident's incident.

Failing to ensure clear direction related to the resident's need for frequent monitoring after the resident's medical incident may have resulted in an unassessed change or deterioration in the resident's health status.

Sources: Complainant, resident health record including vital signs, Digital Prescriber's Orders and interviews of the family, physician, and agency registered staff and the DOC. [110]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other 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.

Rationale and Summary

A complaint was received by the Director from the family of a resident related to concerns of improper care to their altered skin integrity.

Three assessments from a wound care specialist recommended the resident be assessed for a specialty aid. There was no collaboration with staff including the Occupational Therapist (OT) on the specialty aid recommendation. Months later, the OT became aware of the resident's altered skin integrity and recommended the specialty aid, previously recommended by the wound care specialist, to prevent

altered skin integrity exacerbation and promote healing. The specialty aid was then implemented.

Two assessments from a wound care specialist recommended an increase to the resident's calories and protein for altered skin integrity healing. There was no collaboration with the Registered Dietitian (RD) regarding these recommendations.

Failure to collaborate in the development and implementation of the resident's plan of care placed the resident at risk for their skin integrity concerns not being properly met.

Sources: Skin and wound evaluations; RD and OT assessments and referrals, wound care specialist consultation reports. Interviews with wound care specialist, RD, OT and skin and wound lead. [110]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure when a person who has reasonable grounds to suspect abuse of a resident by anyone has occurred, they immediately report the suspicion and the information upon which it is based to the Director.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" includes any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Rationale Summary

Personal support workers reported that a resident approached another resident with a sharp item, swiping at them with the item and verbally threatening them with harm. The item was removed from the resident's grasp and the two residents were
separated. Review of the video camera footage did not confirm if the item made contact with the other resident.

Interviews revealed that a personal support worker informed the registered practical nurse (RPN) of the incident. The RPN reported the altercation but did not report the threatening actions and remarks of a resident towards the other resident as emotional abuse. Physical abuse was reported the Director two

days later, after the DOC viewed camera footage of incident.

Failing to report a suspected emotional abuse of a resident towards another resident delayed an immediate investigation and support to the residents.

Sources: Camera footage, interviews with PSW #122, #118, RPN #114, critical incident report and resident health records.[110]

WRITTEN NOTIFICATION: Directives by Minister

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that a Minister's operational or policy directive was followed related to COVID-19 testing in the home.

Rationale and Summary

Section nine of the Minister's Directive, dated August 30, 2022, stated licensees were required to ensure that the COVID-19 screening requirements, as set out in the COVID-19 Guidance for Long Term Care Homes in Ontario or as amended, were followed, specifically that all residents are assessed at least once a day for the signs and symptoms of COVID-19 including temperature checks.

The home utilized a daily active screening form in Point Click Care (PCC) to monitor residents for the presence of COVID-19 signs and symptoms. The form included the signs and symptoms of COVID-19.

A resident was admitted to the home. Using the daily active screening form, the resident was actively screened on day one, two and four but not on day three. The resident displayed symptoms on day four and tested positive for COVID-19.

Failing to adhere to the requirement for daily screening for early identification and intervention, posed a risk of transmitting the COVID-19 virus to residents, visitors, and staff.

Sources: Review of the resident's daily active screening forms and progress notes. Interview with ADOC/ former IPAC lead. [110]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 14.

The licensee failed to ensure that every plan of care includes hydration status and any risks relating to hydration.

Rationale and Summary

A complaint was received from the family of a resident with concerns around the resident's care, including hydration status.

A record review revealed the Registered Dietitian (RD) assessed the resident's nutrition and hydration needs related to their alteration in skin integrity. The RD's assessment identified the resident was not meeting their fluid requirement. The RD acknowledged that fluid was an important component of wound healing, and a fluid assessment was part of the home's dietary policy for altered skin integrity care but did not identify a plan of care to address the fluid shortfall or risk of inadequate fluid intake for the resident. A plan to promote the resident meeting their estimated fluid needs to address the hydration risk was not in place.

Failure to ensure a plan of care for the resident's hydration status and risk could have compromised the resident meeting their estimated fluid needs and skin integrity.

Sources: Resident's nutrition assessments and RD interview. Policy Dietary Measures for Wound Care Policy XI-G-20.80, dated November 2021. [110]

WRITTEN NOTIFICATION: Personal Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 36

The licensee failed to ensure that a resident received individualized personal care, including hygiene care, on a daily basis.

Rationale and Summary

A complaint was received from the family of a resident related to concerns of improper peri-care, following hygienic practices.

A resident's plan of care indicated they required assistance from staff for continence care. Information was shared and an interview with a PSW revealed the resident had not received proper continence care when they had been bowel incontinent. An interview with the ADOC revealed they were aware of the family's concern, investigated and confirmed the resident had not received individualized peri-care with hygienic practices that day, when they were incontinent of bowel.

Failing to provide proper cleaning during continence care can lead to resident discomfort and infections.

Sources: digital source with date and time. Follow-up question report for bowel continence, resident's plan of care. Interviews with complainant, PSWs and ADOC. [110]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.

The licensee failed to ensure that the home's skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented for a resident.

Rationale and Summary

A complaint was received from the family of a resident related to concerns of improper care of altered skin integrity.

A review of the home's policy titled 'Skin and Wound Management Protocol', dated November 2020, directed the Skin Care Coordinator/Resource Nurse to confirm the stage of all pressure injuries using the National Pressure Ulcer Advisory Panel (PUAP) criteria. The policy also stated the care community will identify a nurse (or nurses), who has (have) enhanced knowledge and skills in the skin and wound care as the Skin & Wound Care Coordinator/Resource Nurse.

The home identified a skin and wound lead RPN as the Skin & Wound Care Coordinator/Resource Nurse.

A record review of weekly skin assessments, completed by nursing staff, over a three month period, identified the resident's area of altered skin integrity and an associated stage. A review of the external wound care specialist, at the time of their assessments identified the same area of altered skin integrity but identified a different stage. The skin and wound lead indicated they do not confirm the stages of areas of altered skin integrity, as determined by nursing staff, according to the home's policy. They further stated they were unfamiliar with staging and the National Pressure Ulcer Advisory Panel (PUAP) criteria and relied on the external wound care specialist for proper staging. The skin and wound lead confirmed they did not have enhanced knowledge on skin and wound management and were not provided skin and wound management training. A review of the lead's annual training records failed to include any training on skin and wound care in 2022.

Failing to ensure an enhanced knowledge and skill level of the skin and wound lead in skin and wound care management, according to the home's policy, may not facilitate the oversight and training of nursing staff and the correct measures and treatment to promote wound healing.

Sources: Skin and wound evaluations, wound care specialist consultation reports, treatment administration records, Skin and Wound Management Protocol policy VII-G-10.92, dated November 2020. Interviews with wound care specialist nurse and skin and wound lead #106. [110]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee failed to ensure that when a resident exhibited a left buttock wound they received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Rationale and Summary

A complaint was received by the Director with concerns that a resident's area of altered skin integrity was not being properly managed.

A resident had an area of altered skin integrity identified. The Registered Dietitian (RD) was referred for nutrition/hydration assessment and treatment a month later. The resident was not assessed by the RD until two months later. The RD was unsure why the resident's assessment was delayed.

A resident's area of altered skin integrity was referred to the wound care specialist consultant Enterostomal therapy (ET) nurse for assessment and treatment to promote healing and prevent infection. Treatment recommendations made during each monthly assessment, for three months, were not implemented until four days later. A later assessment and treatment recommendations were not implemented until six days later. The skin and wound lead stated the ET nurse made recommendations usually on a Thursday and that they did not process the recommendations until their skin and wound day which was on a Monday. The resident's area of altered skin integrity deteriorated and required antibiotic treatment for an infection.

Failing to provide immediate treatment and intervention may impact the healing of altered skin integrity and increase the risk of infection.

Sources: Wound Care Specialist consultation report, orders, treatment administration records. Interviews with ET nurse #126, skin and wound lead #106, RD. [110]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required.

Rationale and Summary

A resident was admitted to the home. Three days later the resident exhibited respiratory symptoms. Four days later the resident remained symptomatic and was referred to the nurse practitioner who at placed the resident on isolation and required testing for the presence of an infection. The resident's test results revealed they had an infection. The ADOC, former lead of infection prevention and control, indicated the registered staff should have isolated the resident on day three, with the first onset of symptoms.

Failing to ensure that a resident was immediately isolated at the onset of symptoms increased the risk for infection transmission to other residents.

Sources: Review of a resident health records and interviews with RPN #101 and ADOC #131. [110]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)

The licensee failed to ensure that when a verbal complaint was received that a documented record was kept which included the following, the nature of each verbal 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

A complaint was received from the family of a resident related to concerns of improper care.

The Family Experience Coordinator (FEC), Assistant Director of Care (ADOC) and Executive Director (ED) acknowledged, in separate interviews, that the identified resident's family had verbally expressed care concerns in 2022. Both staff stated they had not kept a documented record of the family's verbal complaints. The home's complaint records for 2022 were reviewed and it was confirmed that there were no records of any verbal complaints received from the resident's family.

Failing to ensure a documented record of verbal complaints was kept may have led to complaints being unaddressed and not meet the resident's care needs.

Sources: Complaint Log of 2022. Interviews with complainant, RN #125, Resident, Family Experience Coordinator, ADOC #131 and ED. [110]

WRITTEN NOTIFICATION: Additional Training - Direct Care Staff

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.

The licensee failed to ensure that training related to pain management including pain recognition of

specific and non-specific signs of pain, was provided to all staff who provided direct care to residents.

Rationale and Summary

A complaint was received from the family of a resident, related to the resident's care and pain management of an injury.

An agency RPN #117, worked days and agency RPN #121 worked evenings on the same day. At the time the resident experienced a medical incident and developed pain that was, days later, diagnosed as a significant change in health status. Both agency RPN's stated the identified day was their first shift at Altamont and they had not received orientation or training prior to working their shift. RPN #117 was unaware of the home's pain management program and the pain assessment required when the resident experienced unrelieved pain after they administered an 'as needed' pain medication.

The Ministry of Long-Term Care's training requirements included pain management and pain recognition of specific and non-specific signs of pain. The Executive Director (ED) confirmed the scheduler in place last year was currently off and they did not have access to any training records from this time. During this inspection however, agency RPN #127 was working their first shift in the home. No orientation or training was provided prior to this RPN's first shift.

Failing to ensure orientation and training prior to a staff providing direct care to residents leads to an inconsistent standard of care for pain management being provided and ultimately pain relief for the resident.

Sources: Sienna's Training and Orientation Program for agency staff, interviews with Agency RPN #117 and #121, #127, Team Member Experience Coordinator, Executive Director. [110]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (iii)

The licensee failed to ensure that resident #001's area of altered skin integrity was assessed by a registered dietitian (RD) who is a member of the staff of the home.

Rationale and Summary

A complaint was received from the family of a resident related to concerns of improper skin care and the resident's dehydration.

A resident had an area of altered skin integrity identified. The RD, who was a member of the staff of the home, did not assess the resident until three months later. The skin and wound lead acknowledged a referral to the RD should have been initiated when the wound was identified. A referral was sent a month later. The RD was unsure why their assessment of the resident was not completed for two months after the referral was sent.

The failure to assess the resident's nutrition and hydration needs for adequate energy, protein, fluid and nutrients may have delayed the healing of the skin while impacting pain and infection.

Sources: Resident's health record including RD assessments. Skin and wound evaluations. Home's policy entitled 'Skin and Wound Care Management Protocol' VII-G-10.92, dated November 2021. Interview with RD and skin and wound lead #106. [110]

WRITTEN NOTIFICATION: Registered Dietitian

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 74 (2)

The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

Rationale and Summary

In March 2022, the home had 159 licensed beds and required 79.5 hours per month of Registered Dietitian (RD) time. An interview with RD #104 confirmed they started mid March 2022, completed orientation for a few days and only worked two days or 16 hours carrying out clinical work in March 2022. An interview with the office manager and a review of RD #104 hours for March 2022 confirmed they worked 16 hours. A review of RD #128's termination letter revealed they did not work in March 2022. A further review of an invoice from RD #133, an RD from another Sienna home, revealed they worked 18 hours at Altamont in March 2022. The home had a shortfall of 45.5 RD hours in March 2022.

Failing to provide the required RD time could delay responding to referrals and impacting resident's

having their nutrition and hydration needs assessed in a timely manner.

Sources: Letter of RD #128 termination. Invoice of RD #133. Interviews with office manager, RD #104 and Executive Director. [110]

COMPLIANCE ORDER CO #001 Plan of Care

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

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

1. Retrain all registered staff, including agency registered staff, who work on Home Area 3 on the policy for processing physician orders including when to refer to and notify the registered dietitian and revising the resident's plan of care. Maintain a documented record of all retraining provided including the date the training was provided and staff name. Make this record available to the inspector upon request.
2. All nursing staff, including agency staff, who work on Home Area 3 shall review resident #001's current plan of care related to hydration to ensure they are aware of the resident's current hydration needs. Maintain a documented record of all nursing staff who have reviewed resident #001's current plan of care related to hydration and make available to inspector upon request.

Grounds

The licensee shall ensure that resident #001 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.

Rationale and Summary

A complaint was received from the family of resident #001 related to concerns of improper care of an area of altered skin integrity and hydration.

Record review identified a physician's order was written, to discontinue an intervention related to resident #001's fluid intake. A review of the resident's plan of care,

during an interview with the Registered Dietitian (RD), confirmed the intervention was still in place and had not been discontinued. The RD stated a

posted fluid intervention sign remained above the resident's bed and PSWs also confirmed the intervention was still in place. After reviewing the physician's order, the RD acknowledged the resident's plan of care had not been revised when the resident's fluid intervention was discontinued and for eight months continued until the inspector brought awareness to the discontinued order. The RD stated they did not receive a referral from nursing when the resident's fluid intervention order was discontinued and it was not identified when they reassessed the resident four months later, in response to a referral for a

worsening area of altered skin integrity.

Failure to review and revise resident #001's plan of care related to a discontinued fluid intervention could have compromised their skin healing, for a period of eight months, as the resident's fluid requirement increased to amount higher than the fluid intervention amount that remained in place.

Sources

: Resident #001's health record, signage related to the resident's fluid restriction. Interviews with PSWs #110, #113, #116 and RD. [110]

This order must be complied with by

June 1, 2023

COMPLIANCE ORDER CO #002 Skin and Wound Care

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

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, including agency registered staff providing wound care on Home Area 3 regarding the directions on how to assess and document the resident's altered skin integrity using the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

2.

Keep a documented record of the education content provided to staff, including the individual who provided the education, those who attended, and the date of the training.

3.

Develop and implement a monitoring system for the skin and wound care program. Designate a registered staff lead to oversee the implementation of the system. Conduct on-site audits of the

monitoring system for a two-week period to ensure that registered staff are adhering to the training. Analyze audit results and provide re-education/training, as needed. Maintain a documented record of the monitoring system and audits conducted.

Grounds

The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, including skin breakdown was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Rationale and Summary

A complaint was received by the Director from the family of a resident with concerns related to improper care.

A review of the resident's weekly skin assessments and progress was completed with the skin and wound lead and identified the following:

The resident's health record indicated the resident developed an area of altered skin integrity on an identified date. Weekly skin assessments were not subsequently documented for three weeks. In the following month, only two out of four weekly skin assessments were documented. The weekly skin assessments, leading up to the resident's hospitalization, were incomplete with a picture of the area of altered skin integrity but no description of the altered area bed, including signs of infection, exudate, peri-wound, wound pain, orders, treatment, or progress. The skin and wound lead reviewed the picture and described the area of altered skin integrity as deteriorating. The resident was hospitalized a few days later.

Following the return from hospital and a skin assessment was completed, the next weekly skin assessment was not documented until three weeks later, although incomplete. There were no weekly skin assessments of the area of altered skin integrity completed for six weeks leading to a weekly skin assessment that indicated the area had deteriorated. The following month, weekly assessments were not completed and the resident started on antibiotics for an infection in the area of altered skin integrity. The resident remained on antibiotic treatment for at least three months.

The weekly skin assessments required staff to complete a description of the area of altered skin integrity bed and identifying signs, including odour, as evidence of the presence of infection, exudate, peri-wound, wound pain, orders, treatment, and progress. The progress of the skin area included an assessment of area as improving, stable, stalled, deteriorating, monitoring or resolved. The PSW who provided care to the resident, prior the resident's hospital transfer, described the resident's altered skin integrity as appearing worse and with an odour. The skin and wound lead in the home acknowledged

the missing and incomplete weekly skin assessments related to resident #001's area of altered skin integrity.

Failing to complete weekly skin assessments for a resident who developed an area of altered skin integrity may have resulted in a deterioration of the skin area and staff not taking appropriate actions.

Sources:

Skin and wound weekly assessments, interviews with complainant PSW #116 and Skin and Wound lead. Home's Skin and Wound Care Management policy, VII-G-10.92, dated November 2021. [110]

This order must be complied with by

June 1, 2023

COMPLIANCE ORDER CO #003 Pain Management

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 57 (2)

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

Specifically the licensee shall:

1. Ensure all agency registered staff receive the required training, specifically but not limited to, pain management and pain recognition of specific and non-specific signs of pain prior to working their first shift.
2. Keep a documented record of the education content provided to staff, including the individual who provided the education, those who attended, and the date of the training.
3. Develop and implement a monitoring system for the adherence of the pain management program. Conduct on-site audits of the monitoring system for a three-week period to ensure that agency registered staff are adhering to the training. Analyze audit results and provide re-education/training, as needed. Maintain a documented record of the monitoring system and audits conducted.

Grounds

The licensee of a long-term care home failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

A complaint was received by the Director from the family of a resident, regarding the resident's care and pain management related to an injury.

A resident experienced a witnessed medical incident. Agency RPN #117 attended to the resident. Their documentation did not include evidence of pain at the time of the incident but that they notified the doctor and was directed to monitor the resident frequently. During the following shift, the resident complained of moderate pain to an identified area and was given pain medication by agency RPN #121 which was ineffective. The resident was not then assessed, using a clinically appropriate assessment instrument specifically designed for pain, when their pain was not relieved. The following day the resident's pain level was recorded as an 8/10. The resident continued to experience pain according to progress notes. A few days later, the physiotherapist documented the resident had a lot of pain with slight movement and the nurse practitioner documented the resident's reduced range of motion due to pain. Five days later, the family of the resident requested that the resident received PRN pain medication between their scheduled doses since the resident was unable to voice if they were in pain. On the fifth day a pain assessment, using a clinically appropriate assessment instrument, was

completed. At the time of the assessment the resident's pain was documented as 'excruciating'. On day six day the resident's x-ray confirmed a significant change in the resident's health status.

Agency RPN #121 could not recall the circumstances around the identified resident and their pain.

Failing to complete an assessment of the resident's pain, using a clinically appropriate assessment instrument, when the resident experienced unrelieved pain resulted in the resident not receiving an earlier assessment to assist in managing their ongoing pain and discomfort.

Sources:

Resident's health record, assessments, pain level. Interviews with RPN #117, RPN #121 and the DOC. [110]

This order must be complied with by

June 1, 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.