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: June 7, 2023	
Inspection Number: 2023-1279-0002	
Inspection Type: Critical Incident System	
Licensee: MacGowan Nursing Homes Ltd.	
Long Term Care Home and City: Braemar Retirement Centre, Wingham	
Lead Inspector Alicia Campbell (741126)	**Inspector Digital Signature** Alicia Campbell Digitally signed by Alicia Campbell Date: 2023.06.08 10:52:15 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29, 30, 31, 2023 and June 1, 2, 2023

The following intake(s) were inspected:
- Intake #00087139 - related to a fall of a resident resulting in injury

The following intake(s) were completed in this inspection:
- Intake #00013719 - related to a fall of a resident resulting in injury
- Intake #00016338 - related to a fall of a resident resulting in injury

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

Infection Prevention and Control
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)
FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provide direct care to the resident.

Logo's posted in the residents room, the residents care plan and the residents most recent physiotherapy assessment indicated different levels of transfer status for the resident.

The logo's in the resident's room and the resident's care plan were updated to be consistent with the residents most recent physiotherapy assessment.

Sources: resident's care plan; resident's progress notes; Physiotherapy referral; Observations of the residents room; Interviews with staff.

[741126]

Date Remedy Implemented: June 2, 2023

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 (2)

The licensee has 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 resident had a fall that resulted in new pain. The resident began receiving pro re nata (PRN) pain medication multiple times daily to manage their pain and required an increased level of assistance with mobility than before. This pain management strategy continued for seven days, then the physician was informed of the resident's ongoing pain and ordered a higher dose of the PRN pain medication for the resident.

The homes policy indicates a pain assessment should be completed when a resident has a change in condition with onset of new pain, following initiation of, or any changes in pain medication, and when PRN pain-related medication is used frequently over the course of a calendar month.

The resident did not have a pain assessment completed for them in regard to their ongoing pain, change in condition, increased use of PRN pain medication, or when their pain was not relieved by the initial pain interventions.

Completing a pain assessment may have identified patterns of the resident's pain, if certain activities aggravated or alleviated the pain, and if the resident's pain was improving or worsening. This could have informed next steps of care for the resident in terms of their pain management.

Sources: resident's care plan; resident's progress notes; resident's physicians orders; resident's EMAR and PRN medication audit form; review of assessments completed for the resident; The homes Pain Assessment and Management Policy dated May 10, 2022; Interviews with staff.

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Rationale and Summary

A resident had a fall which resulted in new pain and required an increased level of assistance with

ambulation. The resident was transferred to the hospital the next day. The resident returned the same day with ongoing pain and continued requiring an increased level of assistance with ambulation.

A Critical Incident (CI) report was not submitted to the Ministry until the resident had another fall. The DOC indicated that the resident had a significant change in status after their initial fall, and a separate CI should have been submitted to the Ministry at that time.

By reporting this incident late, it could have prevented the Director from intervening as necessary.

Sources: A Critical Incident report; Interview with DOC.

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