

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

609 Kumpf Drive, Suite 105 Waterloo, ON, N2V 1K8 Telephone: (888) 432-7901

	Original Public Report
Report Issue Date: October 27, 2023	
Inspection Number: 2023-1341-0005	
Inspection Type:	
Critical Incident	
	by its general partners Extendicare LTC Managing II GP
Inc. and Axium Extendicare LTC II GP II	
Long Term Care Home and City: Colur	nbia Forest, Waterloo
Lead Inspector	Inspector Digital Signature
Kailee Bercowski (000734)	
Additional Inspector(s)	
None	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 24 - 26, 2023

The following intake related to falls prevention and management was inspected:

• Intake #00097658, CI 2856-000022-23

The following intakes were completed:

- Intake #00098406, CI 2856-000023-23 related to falls prevention and management
- Intake #00098734, CI 2856-000024-23 related to the prevention of abuse

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control Falls Prevention and Management



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INSPECTION RESULTS

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.

The licensee has failed to monitor the effectiveness of pain management strategies.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the monitoring of residents' pain management strategies, and their effectiveness, was complied with.

Specifically, the licensee had not complied with their "Pain Assessment and Management" policy ID# CARE8-O10.01, last reviewed March 31, 2023.

The policy indicated for staff to initiate 72 hour pain monitoring after a resident's change in condition, and once completed, for nursing to conduct an evaluation of the pain monitoring to ensure sufficient management, as well as a comprehensive pain assessment on PointClick Care. The evaluation and comprehensive pain assessment were not completed on the third day following a resident's change in status.

Rationale and Summary

A resident had a change in status, and 72-hour pain monitoring was initiated.

After the third day of pain monitoring, an overall evaluation of pain monitoring strategies and comprehensive pain assessment were not documented. After this date, the resident was documented with further expressions of pain, along with continued pain interventions by registered staff.

In an interview with the Director Of Care, they confirmed an overall evaluation of pain management strategies and a comprehensive pain assessment were not completed following the third day of pain monitoring.

When this policy was not complied with, a resident was at risk of their pain not being managed.

Sources: Interview with the Director of Care; LTCH's policy for Pain Assessment and Management ID# CARE8-O10.01; a resident's clinical records. [000734]