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: October 24, 2023
Inspection Number: 2023-1016-0003
Inspection Type: Critical Incident Follow up
Licensee: CVH (No. 2) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Maitland Manor, Goderich

Lead Inspector	**Inspector Digital Signature**
JanetM Evans (659)	Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2023.11.14 13:52:02 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12 -13, and 16 -18, 2023

The following intake(s) were inspected:
- Intake: #00095989 - Follow-up to related to resident/staff communication response system
- Intake: #00097396 - Related to missing resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1016-0002 related to O. Reg. 246/22, s. 20 (g) inspected by JanetM Evans (659)

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

Safe and Secure Home

Infection Prevention and Control
Responsive Behaviours
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised at when their care needs changed.

Rationale and Summary

It was reported to the home that the resident may have been experiencing an acute mental health episode.

An assessment of the resident's current mental health status was completed and was different from their baseline.

The assessment documented an intervention was initiated and the charge nurse communicated this directly to on-duty staff as well as the Manager on call.

The resident had an exacerbation of their mental health the next day.

There were no updates or documentation to indicate that the intervention was implemented.

There were no updates to include the new interventions or monitoring until following the exacerbation of the resident's symptoms nor had the plan of care been updated to provide direction to staff related to interventions until that time.

Sources: Mental Health - P4 Suicidality Screener - V 2 dated August 30, 2023, care plan, Documentation survey report August and September 2023, interviews with DOC, ED and staff
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WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that care set out in the plan of care was provided to a resident as set out in the plan of care.

Rationale and Summary

A resident had an acute medical episode.

An assessment documented risk of harm and that the resident needed to be monitored at certain intervals.

Clinical records showed instances where documentation of the monitoring was completed in batches prior to the timeline the check was due and or not completed at all.

The BSO lead and the DOC stated it was not best practice for staff to document the monitoring ahead of the timeline the checks were due.

Failing to complete the monitoring as per the plan of care for a resident, put the home at risk of not being able to intervene in a timely fashion if required to mitigate harm.

Sources: plan of care, progress notes, Documentation survey reports for August and September 2023, Mental Health - P4 Suicidality Screener - V 2 dated August 30, 2023 and September 21, 2023. interviews with BSO and DOC
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WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee failed to ensure 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 history of chronic pain.

Their plan of care directed staff to administer analgesics and record pain site, scale and effectiveness. There were no non-pharmacological pain interventions documented in the plan.

The home's policy for pain management directed staff to determine the effectiveness of the pain intervention following its implementation but did not direct the staff to a timeline for this.

The electronic medication administration records (eMAR) showed times where staff were not following up with the resident to check the effectiveness of the pain medication administered for six to ten hours following its administration.

Clinical records showed the resident's pain fluctuated between moderate to high levels. On two instances documentation indicated the intervention with medication was ineffective. No re-assessment of the resident was completed for pain using a clinically appropriate assessment instrument specifically designed for this purpose when the initial pain interventions were not effective.

The DOC acknowledged no pain re- assessment had been completed using a clinically appropriate assessment instrument specifically designed for this purpose when the intervention was ineffective.

Failing to re-assess the resident in a timely manner for effectiveness of the initial pain interventions or when initial pain interventions were ineffective prevented the home from ensuring the resident received appropriate and effective pain management solutions.

Sources: eMAR - August and September 2023, physician's orders, policy Pain identification and management, RC 19-01-01, last reviewed March 2023; interviews with DOC and staff.
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