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

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Original Public Report

Report Issue Date: October 9, 2024
Inspection Number: 2024-1016-0005
Inspection Type: Proactive Compliance Inspection
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 21-23, 26-29, 2024, and September 3-6, 9-10, 2024.

The inspection occurred offsite on the following date(s): August 27, 2024.

The following intake was inspected:

- Intake: #00123530 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Residents' and Family Councils
Infection Prevention and Control

Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Advice

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 43 (4)

Resident and Family/Caregiver Experience Survey

s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee failed to seek the advice of the Residents' Council (RC) in carrying out the Residents and Family Satisfaction Survey.

Rationale and Summary

Maitland Manor Long-Term Care Home's (LTCH) corporate office created the Residents and Family Satisfaction Survey for 2023, and the LTCH did not seek the advice of the Residents' Council in carrying out the survey.

When the RC was not provided an opportunity to advise the home in carrying out the Residents and Family Satisfaction Survey, their suggestions were not incorporated.

Sources: RC Meeting Minutes; Interview with the Executive Director (ED).

WRITTEN NOTIFICATION: Air temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 24 (1)

Air temperature

s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

A review of the home's air temperature tracking sheets for August 2024 and September 1-3, 2024, indicated the temperatures were not maintained at a minimum temperature of 22 degrees Celsius on 51 occasions in August and on 19 occasions between September 1-3, 2024.

The recorded temperatures ranged from 19.9 degrees to 21.9 degrees Celsius.

There was risk for resident discomfort when the temperatures was not maintained at a minimum of 22 degrees Celsius.

Sources: Air Temperature Tracking Sheets August, 2024, and September 1-3 2024; Interview with the Environmental Services Manager (ESM).

WRITTEN NOTIFICATION: Air temperature

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 24 (3)

Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee failed to ensure that the temperature was documented at least once every afternoon between 12 p.m. and 5 p.m., and once every evening or night.

Rationale and Summary

A review of the home's air temperature tracking sheets for August and September 2024, indicated that the temperature was not taken during the evening or night in August, 2024 on 7 occasions and not taken during the afternoon, between 12p.m. and 5p.m on 5 occasions in August and on September 1, 2024.

The Environmental Services Manager (ESM) acknowledged that several temperature recordings were not taken.

There was risk for resident discomfort when the air temperatures were not recorded at the required times and out-with the afternoon hours between 12p.m. and 5p.m.

Sources: Air Temperature Tracking Sheets August, 2024 and September 1-3, 2024; Interview with the ESM.

WRITTEN NOTIFICATION: General requirements of programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section

53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to ensure the home's pain management program was reviewed on an annual basis.

Rationale and Summary

The home's Pain Management Lead RN#114 reported the home's Pain Management Program evaluation from April 2024 had focused on review of the home's compliance with the policy, and had not included a review of the home's policies related to pain management.

During the inspection, the home's Pain Management Lead identified a different prevailing reassessment practice expectation for registered staff than what was included in the licensee's policy. Registered staff reported implementing the policy's processes, not the prevailing practices.

When the home's Pain Management Program, including the relevant policies, were not reviewed on an annual basis, they were not updated in accordance with prevailing practices. There was therefore increased risk of staff not applying prevailing practices for pain assessment in the home.

Sources: Interviews with registered staff and other staff; The home's Pain Management Program (Policy ID# RFC-03-21, August 2024), and the home's most recent Pain Management Program Evaluation record from April 2024.

WRITTEN NOTIFICATION: General requirements for programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

General requirements

s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:

4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee failed to ensure a written record was maintained in accordance with the Regulation for the home's annual evaluation of the skin and wound program, as well as the pain management program.

Rationale and Summary

A) The home's skin and wound care program was reported to have been evaluated in June 2024.

The written record associated with the evaluation did not include the full date of the program's evaluation, or the dates of implementation for the proposed changes.

When the dates were not included for the evaluation, there was increased risk of process inefficiency.

Sources: Interviews with DOC; The home's most recent Skin and Wound Care

Program Evaluation record from June 2024.

B) The home's pain program was reported to have been evaluated in April 2024.

The written record associated with the evaluation did not include the full date of the program's evaluation, or the dates of implementation for the proposed changes.

When the dates were not included for the evaluation, there was increased risk of process inefficiency.

Sources: Interviews with DOC #102; The home's most recent Pain Management Program Evaluation record from April 2024.

WRITTEN NOTIFICATION: Staffing evaluation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and summary
Review of staffing evaluation indicated that it was completed May 2024.

The written record associated with the evaluation did not include the full dates of implementation for the proposed changes.

When the dates were not included for the evaluation process, there was increased risk of inefficient changes to the program.

Sources: Interviews with DOC #102; The home's most recent Staffing evaluation record from May 2024.

WRITTEN NOTIFICATION: Required programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee failed to ensure the home's skin and wound care program was implemented.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home's skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, as well as provide effective skin and wound care interventions, was complied with.

Specifically, the licensee did not comply with their Preventative Skin Care policy

(ID# RFC-06-01), which directed the home's Wound Care Lead or designate to conduct wound rounds weekly, at minimum, and more often as necessary. During the rounds, the Wound Care Lead was to consider reviewing follow up required for improvement (of residents' wound and skin care concerns), as well as education needs for staff.

Rationale and Summary

A) Altered skin integrity was identified for a resident and a referral to the home's Wound Care Champion was initiated. The home's process for initial wound assessment, as well as weekly reassessment, was not initiated for both skin tears during the 27-day period.

A new skin issue was identified for the same resident and a referral to the home's Wound Care Champion was initiated. Concerns were identified with the appropriate completion of the wound's weekly reassessments by multiple registered staff during the 19-day period.

B) An altered skin integrity was identified for a resident and a referral to the home's Wound Care Champion was initiated five days after the issue had been assessed as resolved by other staff at the home. Concerns were identified with the appropriate completion of the wound's weekly reassessments by multiple registered staff during the 28-day period.

The home's Skin and Wound Care Lead reported Wound Care Champion referrals should be completed within a weekly timeline. They noted the August 2024 referrals for the wounds of two residents were not completed as per the home's processes. At the time of inspection, they indicated that the home had not identified concerns with the completion of wound assessments, and the home had not initiated education on the home's skin and wound assessment procedures for all

registered staff.

When the Wound Care Champion referrals were not completed for the wounds of the residents they were at increased risk of ineffective wound care intervention(s).

Sources: Interview with the home's Skin and Wound Care Lead/Wound Care Champion; Clinical records for residents, as well as the home's skin and wound care program resources, including the Preventative Skin Care policy (ID# RFC-06-01).

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 (1) 3.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

The licensee failed to ensure strategies for pressure reduction and prevention of skin breakdown were implemented for a resident at admission, in adherence with the home's skin and wound care program.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home's skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, as well as provide effective skin and wound care interventions, was complied with.

Specifically, the home's Preventative Skin Care policy (ID# RFC-06-01,) directed

registered staff to develop and document strategies to prevent skin breakdown for all residents who were assessed to be at greater risk for skin breakdown and pressure ulcer development. The strategies were to be documented on the resident's care plan, and would include strategies to reposition residents, as well as the use of pressure reduction devices to reduce and relieve pressure on bony prominences.

Rationale and Summary

A resident was assessed to be at high risk of pressure ulcer development and required assistance from staff with activities of daily living.

The home's Skin and Wound Care Lead said residents who were at high risk of pressure ulcers, and who were admitted to the home with requirements for assistance from staff with activities of daily living and mobility, should have received an intervention in their care plan for turning and repositioning. The resident's care plan was not updated with the intervention until 16-days after their admission.

They further indicated that residents who were at high risk of pressure ulcers, and used an assistive device for mobility should have received an intervention to help reduce and relieve pressure on bony prominences. The resident's care plan was not updated with the intervention until 38-days after their admission.

When the resident's initial plan of care was not developed with interventions for their assessed preventative needs related to skin and wound care, the resident was at increased risk of skin breakdown.

Sources: Interviews with the home's Skin and Wound Care Lead; Resident's clinical records, and the home's Preventative Skin Care policy (ID# RFC-06-01, last revised in December 2023).

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure a resident received a clinically appropriate assessment when registered staff identified two new skin tears.

Rationale and Summary

A resident was identified by RN to have altered skin integrity. No wound assessments were initiated.

The home's Skin and Wound Lead said RN should have initiated Impaired Skin Integrity Assessments for the altered skin integrity and the wounds should have been reassessed weekly thereafter until resolved.

When a resident's altered skin integrity was not assessed using a clinically the resident was at increased risk of delayed intervention for wound healing.

Sources: Interview with the home's Skin and Wound Lead; Resident's clinical records, and the home's Wound Management Policy (ID# RFC-06-02, Created August 2024,) including Appendix 7 'Skin Issues Checklist'

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure that a resident received immediate treatment and interventions to promote wound healing and prevent infection.

Within Ontario Regulation 246/22, "altered skin integrity" is defined as potential or actual disruption of epidermal or dermal tissue.

Rationale and Summary

At admission a resident was assessed to be at high risk of pressure ulcer development and required an assistive device for ambulation, and assistance from staff with activities of daily living.

The resident was further noted at admission to have chronic pain and received routine pain medications to help manage their pain. When their pain was not relieved by those interventions, the resident had an as needed pain medication that registered staff could administer.

The resident expressed pain on a particular day to a registered staff. However, no pain assessment was completed.

The RPN reported they did not take further action to assess the resident's pain.

The home's Skin and Wound Care Lead said that the resident should have received a comprehensive pain assessment when the resident's new pain was first identified, as well as a head-to-toe assessment of their skin, for a new pressure injury. They further indicated the registered staff should have taken immediate action to help reduce or relieve the resident's pain when it was identified.

When the resident was known to be at high risk of pressure ulcer development, did not receive immediate assessment and intervention for their new expression of pain, they experienced a delay in identification of a new skin concern, and were at increased risk of unmanaged pain.

Sources: Interview with the home's Skin and Wound Care Lead, as well as registered staff; Resident's clinical records, as well as the home's Wound Management Policy (ID# RFC-06-02, last revised December 2023), including it's Skin and Wound Checklist (Appendix 7).

WRITTEN NOTIFICATION: Menu planning

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure a written record was maintained of the home's 2024 Spring-Summer menu cycle evaluation in accordance with the Regulation.

Rationale and Summary

Registered Dietitian (RD) and Food Service Manager (FSM) evaluated the home's 2024 Spring-Summer menu cycle prior to it being in effect.

The home's menu evaluation and approval record for the 2024 Spring-Summer menu cycle was signed off by RD, however, the name and signature of the FSM, summary of changes made and the date the changes were implemented were not documented.

Sources:
Spring 2024 Menu Evaluation & Approval Record; Interviews with RD, and FSM.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (10)
Infection prevention and control program
s. 102 (10) The licensee shall ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 246/22, s. 102 (10).

The licensee failed to ensure that the information gathered under subsection (9) was reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreak.

Rationale and Summary
The Infection Prevention and Control (IPAC) Lead confirmed that within the monthly

Infection Prevention and Control Meetings the analysis of trends and data surveillance is reviewed.

A review of the Infection Prevention and Control Meeting minutes for May, 2024, indicated that the meeting was conducted on July 18, 2024.

The IPAC Lead acknowledged that the monthly review for May was conducted late which may have put the residents at risk of infection trends not being identified.

Sources:
Infection Prevention and Control Meeting Minutes, Interviews with IPAC Lead.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and

The licensee failed to ensure that the Continuous Quality Improvement (CQI) report contained the results of the Residents and Family Satisfaction Survey taken during the fiscal year under section 43 of the Act.

Rationale and Summary
The Residents and Family Satisfaction Survey were conducted from October 2 to 17,

2023.

The CQI initiative report included only one of the opportunities for improvement that needed to be actioned on.

According to the Residents and Family Satisfaction Survey 2023, some of the other opportunities for improvement that needed to be actioned on were the input into recreation programs, quality of care from Social Worker/ Social Service Worker and to ensure the residents care conference is a meaningful discussion that focuses on what's working well, what can be improved, and potential solutions.

The Executive Director (ED) confirmed that the CQI report did not include all of the results from the survey.

Sources:
Residents and Family Satisfaction Survey 2023, CQI Initiative Annual Report, QIP March, 25, 2024, Workplan QIP 2024/25; Interview with the ED.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that the Continuous Quality Improvement (CQI) report contained a written record of the dates when the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

Rationale and Summary
The ED stated that the results of the survey were shared during a Resident Council (RC) meeting, the Family Council (FC) were provided a copy of the survey results, and the staff of the home were informed of the results during team meetings. The ED further stated that a copy of the survey was posted in the home on the quality improvement board and the resident/ family information board in the LTCH.

The home's CQI Initiative Annual Report did not include the dates when the results of the survey were shared.

Sources: Residents and Family Satisfaction Survey 2023, CQI Initiative Annual Report, QIP March, 25, 2024, Workplan QIP 2024/25; Interview with the ED.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services,

programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee failed to ensure that the CQI initiative report contained a written record of the actions taken to improve the LTCH, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions.

Rationale and Summary

According to the 2023 Residents and Family Satisfaction Surveys, some of the opportunities for improvement that needed to be actioned on were the input into recreation programs, quality of care from Social Worker/ Social Service Worker and to ensure the residents care conference is a meaningful discussion that focuses on what's working well, what can be improved, and potential solutions. A written record of the actions taken by the home to improve on these areas, the dates the actions were implemented, and the outcomes of the actions, were not included in the home's CQI initiative report.

The CQI initiative report included the actions taken for one of the results of the survey, related to Spiritual Programming in the home. The report did not include the dates the actions were implemented and the outcome of the actions.

When there was no record maintained in the home that documented the actions taken, as well as the dates the actions were implemented and the outcomes of the actions, the status of the home's action plans and goals were unclear.

Sources: Resident and Family Satisfaction Survey 2023, CQI Initiative Annual Report,

QIP March 25, 2024, Workplan QIP 2024/25; Interview with the ED.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of, v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that the CQI initiative report contained a written record of how, and the dates when, the actions taken under O. Reg. 246/22, s. 168 (2) 6 (i) and (ii) were communicated to the residents and their families, the Residents' Council, Family Council and members of the staff of the home.

Rationale and Summary

The ED indicated that the actions taken under O. Reg. 246/22 s. 168 (2) 6 (i) and (ii) were communicated in a managers team meeting and not shared with the other staff in the home or the RC and FC.

The home's CQI initiative report did not include the above-mentioned information and because the actions taken were not shared with the other staff in the home or the RC and FC, a written record of how, and the dates when, the actions were communicated were not documented.

By not providing the other staff in the home as well as the RC and FC with the information relating to the actions taken in the home, the other members of staff, the RC and FC could not provide feedback.

Sources:
Residents and Family Satisfaction Survey 2023, Continuous Quality Improvement Initiative Annual Report, QIP March 25, 2024, Workplan QIP 2024/25; Interview with the ED,

COMPLIANCE ORDER CO #001 Skin and wound care

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

1. Educate all registered staff on the home's policies relevant to monitoring skin integrity and wound assessment.

    A record will be maintained of the education provided, who received the education, date(s) of when the education was provided, as well as the contents of the education and training materials.

2. Conduct an audit of wound care.

a) The audit will be conducted by a member of the home's management, or clinical leadership team.

b) It will be conducted daily over a two-week period.

c) Identify residents with new or ongoing skin concerns.

d) The audit will review the nursing actions initiated in response to reports of residents' new or identified skin concerns, for adherence with the home's policies.

e) Maintain a record of the audits completed, dates of when the audits were completed.

f) Maintain a record of any action taken when non-compliance is identified, including the dates the corrective actions were taken.

g) Analyze the results of the audits, address any concerns identified, and document the corrective actions taken.

Grounds

The licensee has failed to ensure two residents received weekly reassessments of their wounds.

Rationale and Summary

The home's policy for Wound Management (ID# RFC-06-02) directed registered staff to reassess residents' wounds weekly for healing progression until the wounds resolved. The wound assessments were to include dimensions of the wounds, and when completing each wound assessment, registered staff were directed to take a photograph of the wound and upload it to Point Click Care.

A) A resident had altered skin integrity and they did not receive a weekly wound reassessment. They also did not receive any weekly assessments of new altered skin integrity. The home's Skin and Wound Care Lead said staff should have completed the reassessments on a weekly basis.

B) Another resident had altered skin integrity. The resident was not assessed weekly.

The home's Skin and Wound Care Lead also noted the completed wound assessments for the two residents did not consistently include photos or measurements.

When both residents did not receive weekly reassessments of their wounds as clinically indicated, and the assessments were not completed as per the home's Wound Management policy, they were at increased risk of unidentified wound changes.

Sources:

Interviews with the home's Skin and Wound Care Lead; Resident's clinical records, and the home's Wound Management Policy (ID# RFC-06-02, Created August 2024)

This order must be complied with by October 31, 2024

COMPLIANCE ORDER CO #002 Pain management

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's

pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

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

The licensee shall:

1. Review and revise the home's Pain Management Program Policy as necessary, to ensure registered staff are directed to assess residents with a clinically appropriate tool when the residents' pain is not relieved by initial pain management interventions.

    Maintain a record of the revision process, including:

        i) Meeting dates, times, and notes on discussions held.

        ii) Meeting participants and their designation(s).

        iii) The outcome of the revision, and date of implementation for the revised policy.

2. Educate all registered staff, including agency nursing staff, on the associated policy revisions.

    A record will be maintained of the education provided, who received the education, date(s) of when the education was provided, as well as the contents of the education and training materials.

3. Following the policy revision and implementation, conduct an audit of nursing pain monitoring assessments.

    a) The audit will be conducted by a member of the home's management, or clinical leadership team.

b) It will be conducted daily over a two-week period.

c) Identify residents with new or unrelieved expressions of pain during the audit period.

d) The audit will review the nursing actions initiated in response to reports of residents' new or unrelieved pain, for adherence with the home's policies.

e) Maintain a record of the audits completed, dates of when the audits were completed.

f) Maintain a record of any action taken when non-compliance is identified, including the dates the corrective actions were taken.

g) Analyze the results of the audits, address any concerns identified, and document the corrective actions taken.

Grounds

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

In the event of residents expressing pain that was not relieved by initial interventions, or new pain, the home's Pain Program Lead said registered staff were expected to complete a full pain assessment on Point Click Care indicating details of the pain. The home's V5 pain assessment included the following clinical descriptors of the pain:

- Descriptions of factors that may have provoked or precipitated the pain
- Descriptions of pain timing, such as whether it was constant, occasional, intermittent

- Quality of the pain, such as whether it was radiating, aching, or burning
- Whether the pain radiated from the site
- Sedation scale or other behaviours apparent at time of pain expression
- Severity of the pain using the numerical scale for cognitive residents, or PAINAD scale for residents with cognitive impairments
- Location of the pain
- Referrals initiated to relevant healthcare providers

A resident was identified to have chronic pain, and had two routine pain prescriptions to help manage their pain. In addition, they had a different pain medication prescribed for when further pain management intervention was needed.

No pain assessments were completed when the resident's as needed pain medication were administered.

The home's Pain Management Program Policy indicated for registered staff to only document expressions of pain from cognitive residents using the numerical scale when providing as needed pain medications.

The home's Pain Lead reported the policy at the time of inspection did not direct staff to complete a clinically appropriate assessment tool for assessing residents when their pain was not relieved by initial pain management interventions.

When the home's Pain Management Program did not direct registered staff to complete a clinically appropriate assessment instrument specifically designed for assessment of new pain, or assessing efficacy of pain interventions, the resident was at increased risk of ineffective pain monitoring and management.

Sources: Interviews with RPNs, and the home's Pain Program Lead; Resident's clinical records, as well as the home's Pain Management Program Policy (Policy ID# RFC-03-21, August 2024)

B) The licensee has failed to ensure that when a resident 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

The home's "RFC-03-21, Pain Management Program", created August 2024 indicated for staff to complete a pain assessment for 72 hours on the day, evening shifts and on nights (only if the resident is awake) in the following circumstances using the numerical rating scale for residents able to self-report pain and the PAINAD for cognitively impaired residents:

- Whenever breakthrough pain medication is used for three consecutive days.

- Notify the Physician or Nurse Practitioner as soon as reasonable possible, with an analysis of pain and assessment when 3 or more breakthrough pain medication doses were needed.

A residents' plan of care indicated that the resident had pain and were administered an analgesic for it. The resident also received as needed pain medication for their pain.

No clinically appropriate pain assessments were completed, and the physician was not notified after three or more breakthrough pain medication doses were administered to the resident.

ADOC acknowledged that a comprehensive pain assessment called a "new pain assessment" should have been completed when the resident received as needed medication for breakthrough pain.

Resident was at risk of not receiving the most effective treatment plan, not having their pain managed appropriately and failing to receive a precise diagnosis when they were not assessed using a clinically appropriate assessment.

Sources: Interview with ADOC, SDM, observations, review of LTCH's RFC-03-21, Pain Management Program policy ; Resident's pain assessment, electronic medication administration record (EMAR).

This order must be complied with by October 31, 2024

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.