Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2020	2020_793743_0001	021434-19	Complaint

Licensee/Titulaire de permis

Villa Forum
175 Forum Drive MISSISSAUGA ON L4Z 4E5

Long-Term Care Home/Foyer de soins de longue durée

Villa Forum
175 Forum Drive MISSISSAUGA ON L4Z 4E5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KIYOMI KORNETSKY (743)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 8-10, 13 and 16-17, 2019.

The following intakes were completed in this complaint inspection:

Log #021434-19/ IL 71836-CW - a complaint alleging inadequate pain control for resident #001 prior to their hospitilization.

During the course of the inspection, the inspector(s) spoke with Co-Director of Care (Co-DOC), Behavior Support Ontario (BSO), Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Care Providers (PCP).

The inspector reviewed clinical records, plans of care for relevant residents, pertinent policies and procedures, the home's documentation related to relevant investigations and pertinent staff education and training documents.

The following Inspection Protocols were used during this inspection:
Pain

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, that it was complied with.

In accordance O.Reg. s.48(1) (4), and in reference to O.Reg. s.52 (1)(4), the licensee was required to have a pain management program that included the monitoring of resident's responsiveness to, and effectiveness of pain management strategies.

According to the home’s policy titled Pain and Palliative Care, last reviewed May 2010; the goals and objectives of the home’s pain management program included ensuring resident comfort and working with the resident to establish and maintain a functional level of pain relief or pain control.

Specifically, the policy directed staff that when new interventions such as an analgesic or non-pharmacological method of pain control was implemented, the team member implementing the intervention would evaluate the effectiveness of the intervention as soon as it was reasonable to assume the interventions would be effective. The reassessment/evaluation of the effectiveness was to be documented in the Weights and Vitals tab in PCC and/or progress notes. If the interventions were ineffective, the team was responsible to reassess alternatives to manage or control pain and update the care plan accordingly. This was to be an iterative process until the resident’s pain was under control as defined by the resident.

A complaint was submitted to the Ministry of Long-Term Care alleging that resident #001’s pain was not controlled prior to the resident’s hospitalization.

Resident #001's records were reviewed in Point Click Care (PCC) and over several days, there were multiple progress notes that documented pain or discomfort to a specific area.

i) On the first day at a specific time, Personal Care Provider (PCP) #102 documented that resident #001 had complained of pain to a specific area since the morning; and noted that they had applied a specific treatment, as ordered by the Nurse Practitioner (NP) #109.

Forty minutes later, Nurse Manager (NM) #101 documented that resident #001 exhibited signs of acute pain to the same area. New orders were obtained for pain management, and documentation in the resident's Medication Administration Record (MAR) indicated that thirty minutes after the first dose was administered, the resident's Pain Assessment in Advanced Dementia (PAINAD) recorded moderate pain.

Review of the resident's records found no subsequent progress notes or PAINAD assessments completed on that day to ensure the pain interventions were effective in relieving resident #001's pain.

Co- Director of Care (Co-DOC) #103 acknowledged that staff did not assess resident #001's response to the new treatment, to ensure the treatment was effective in relieving the resident's pain. They also said there was no indication of what action NM #101 took to relieve the resident's pain over a five hour period; nor after the resident's pain was listed as moderate, thirty minutes after receiving a new treatment for pain.

ii) On the second day at a specific time, NM # 104 documented that they applied a treatment to the same area where resident #001 had complained of pain the previous day. A PAINAD assessment was completed at a specific time and the resident was noted to have a level 2 pain, indicating continued mild pain.

Three hours later, NM #104 documented that resident #001 complained of pain to the same area; and documented that the resident's intake was poor that morning.

Later that same day, NM #105 documented that resident #001 continued to exhibit pain with movement; and had received their prescribed pain medication at the specified times, with their most recent dose being two hours prior.

Co-DOC #103 acknowledged that NM #104 and #105, did not re-assess resident #001

when it was noted the resident continued to have pain to the same area. There was also no documentation that NM #104 and #105 reassessed the resident for alternative interventions to manage the resident's pain, when the current interventions were not effective.

iii) On the third day, NM #105 documented that resident #001 continued to exhibit pain to the same area; and noted that pain medication was being administered to the resident as scheduled.

When asked what treatment or assessments were completed when resident #001 continued to complain of pain; NM #105 said they thought only the PAINAD assessment was completed.

iv) On the fourth day, Registered Nurse (RN) #108 documented that resident #001 exhibited signs of acute discomfort, with complaints of pain and would be monitored.

According the resident's MAR, the resident received their standing dose pain medication in the morning and despite the treatment, the resident remained in pain one hour later. There was no further documentation that resident #001 was reassessed or provided alternative interventions to manage their pain, when the current interventions were not effective.

RN #108 was called to assess resident #001 for complaints of pain to the same area, but were unable to assess the area due to the resident's response and reported acuity of pain. Resident #001 was sent to hospital, however, there was no documentation that the resident was reassessed or provided with alternative pain management strategies or treatments prior to their transfer to hospital.

NM #108 said they could not recall if resident #001 was provided with additional analgesics prior to the resident's transfer to hospital, as it was not their role to administer medication. They also said their assessment of the resident was only what was documented in the progress note.

Co-DOC #103 said that no pain interventions were provided to resident #001, while the resident waited to be transferred to hospital.

Documentation indicated that while in hospital, resident #001 required further intervention to manage their discomfort associated with a diagnosed medical condition. The resident

passed away while in hospital and the secondary cause of death was listed as pain resulting from the medical condition.

The licensee failed to ensure that staff complied with the home's Pain and Palliative Care policy, last reviewed May 2010; when they failed to ensure resident #001's comfort by ensuring a functional level of pain relief or pain control. The home also failed to ensure that when new pain interventions were ordered for pain control, that the effectiveness of the interventions were evaluated as soon as it was reasonable to assume the interventions would be effective. Staff failed to assess for alternative interventions to manage and control resident #001's pain, when the pain control interventions were ineffective; and this was to be an iterative process until the resident's pain was under control as defined by the resident. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (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. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee 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.

A) A Complaint was submitted to the Ministry of Long-Term Care alleging that resident #001's pain was not controlled prior to their hospitalization.

Resident #001's records were reviewed in Point Click Care (PCC) and there were multiple progress notes that documented pain or discomfort to a specific area over

several days.

According to Co-DOC #104, the Comprehensive Pain Assessment located in PCC was the home's clinically appropriate assessment instrument specifically designed for pain.

On a specified date and time, resident #001 complained of pain. The pain was assessed using the PAINAD tool and was determined to be moderate pain. NP #109 assessed the resident and prescribed a specific treatment. Later that same day, NM #101 documented that resident #001 exhibited signs of acute pain, and additional pain medication was ordered.

On the second day, NM # 104 documented that treatment was provided for the resident's pain. Three hours later, NM #104 documented that the resident continued to complain of pain to the same area and had poor intake that morning. Later that night, NM #105 documented that resident #001 continued to exhibit pain.

On the third day, RPN #106 documented that treatment was administered after the resident complained of pain. Later that day, Nurse Manager #105 noted the resident continued to exhibit signs of uncontrolled pain, and pain medication was being administered as per schedule.

On the fourth day, RN#108 documented that resident #001 exhibited signs and symptoms of acute discomfort. Approximately two hours later, RN #108 assessed the resident due to continued complaints of pain to the same location, but were unable to assess the area due to the acuity of pain in the identified area.

Resident #001 was subsequently transferred to hospital, where they were diagnosed with an injury that required further interventions.

Record reviews indicated that over the several day period, there was one Comprehensive Pain Assessment initiated by RN #108 on the day resident #001 was transferred to hospital; however, the assessment was not completed until almost three months later.

RN #108 denied completing a Comprehensive Pain Assessment on the day resident #001 was transferred to hospital, and also said they had no recollection of completing the assessment three months later.

Co-DOC #103 acknowledged that staff did not assess resident #001 using the home's Comprehensive Pain Assessment, after initial interventions were not effective in relieving the resident's pain.

Resident #001 passed away while in hospital; and the resident's secondary cause of death was pain, related to a specified medical condition.

B) Resident #003 was diagnosed with an injury on a specific date. The resident had moderate to severe cognitive impairment and both Behavior Support Ontario (BSO) #110 and Co-DOC #103, said the resident would express pain through responsive behaviors.

According to PCP #113, resident #003 exhibited responsive behaviors during care one morning, which they thought was pain related.

RPN #111 documented that PCP #113 had informed them of resident #003's exhibited signs and symptoms of pain, possibly associated with an injury. RPN #111 also identified signs of injury and provided localized treatment which the resident was not compliant with.

Later that morning, NM #113 documented that RPN #114 informed them of resident #003's suspected injury; and the resident was sent to hospital that same morning, where the injury was confirmed.

Review of the resident's assessments in PCC noted that pain assessments were not completed on the morning when resident #003 exhibited signs and symptoms of pain and injury; and DOC #103 confirmed that RPN #114 did not complete the home's comprehensive pain assessment.

According to the Medication Administration Record (MAR), the resident's medication for pain was not changed or increased after the suspected injury. There were no orders for as needed (PRN) pain medication, nor was any additional pain medication documented as being provided.

After the resident's injury, progress notes indicated that on several days, resident #003 had noted pain or discomfort, as well as responsive behaviors that were not relieved by initial interventions.

Review of the resident's records in PCC noted that resident #003 was not assessed using the home's Comprehensive Pain Assessment on the day the injury was first noted, when the resident exhibited signs and symptoms of pain and potential injury; despite continued attempts to provide local treatment. The resident was not assessed using the Comprehensive Pain Assessment over an eight day period after returning from hospital, when the resident was exhibiting responsive behaviors and signs and symptoms of pain.

According to BSO #110 and Co- DOC #103, resident #003 had frequent responsive behaviors; however, they were not able to conclusively determine that the resident was not exhibiting pain after the resident's injury.

The licensee failed to ensure that when a resident #001's pain was not relieved by initial interventions over several days, that resident #001 was assessed using a clinically appropriate assessment instrument specifically designed for pain. The licensee also failed to assess resident #003, who communicated pain through responsive behaviors, with a clinically appropriate assessment instrument specifically designed for pain, when pain was noted and when responsive behaviors were not relieved by the initial interventions. [s. 52. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 27th day of February, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KIYOMI KORNETSKY (743)
Inspection No. / No de l'inspection :	2020_793743_0001
Log No. / No de registre :	021434-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 13, 2020
Licensee / Titulaire de permis :	Villa Forum 175 Forum Drive, MISSISSAUGA, ON, L4Z-4E5
LTC Home / Foyer de SLD :	Villa Forum 175 Forum Drive, MISSISSAUGA, ON, L4Z-4E5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Celia Lisi

To Villa Forum, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) of Ontario Regulation 79/10.

Specifically the licensee must:

a) Ensure that registered staff monitor and document residents' responsiveness to, and effectiveness of all pain management strategies; including standing order pain medications and as needed (PRN) pain medication; as directed in the home's Pain and Palliative Care policy.

b) Ensure an audit tool is developed to ensure staff compliance with the home's pain management policy. The Audit should include who is responsible, the results and the actions taken in relation to the results.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, that it was complied with.

In accordance O.Reg. s.48(1) (4), and in reference to O.Reg. s.52 (1)(4), the licensee was required to have a pain management program that included the monitoring of resident's responsiveness to, and effectiveness of pain management strategies.

According to the home's policy titled Pain and Palliative Care, last reviewed May 2010; the goals and objectives of the home's pain management program included ensuring resident comfort and working with the resident to establish and maintain a functional level of pain relief or pain control.

Specifically, the policy directed staff that when new interventions such as an analgesic or non-pharmacological method of pain control was implemented, the team member implementing the intervention would evaluate the effectiveness of the intervention as soon as it was reasonable to assume the interventions would be effective. The reassessment/evaluation of the effectiveness was to be documented in the Weights and Vitals tab in PCC and/or progress notes. If the interventions were ineffective, the team was responsible to reassess alternatives to manage or control pain and update the care plan accordingly. This was to be an iterative process until the resident's pain was under control as defined by the resident.

A complaint was submitted to the Ministry of Long-Term Care alleging that resident #001's pain was not controlled prior to the resident's hospitalization.

Resident #001's records were reviewed in Point Click Care (PCC) and over several days, there were multiple progress notes that documented pain or discomfort to a specific area.

i) On the first day at a specific time, Personal Care Provider (PCP) #102 documented that resident #001 had complained of pain to a specific area since the morning; and noted that they had applied a specific treatment, as ordered by the Nurse Practitioner (NP) #109.

Forty minutes later, Nurse Manager (NM) #101 documented that resident #001 exhibited signs of acute pain to the same area. New orders were obtained for pain management, and documentation in the resident's Medication Administration Record (MAR) indicated that thirty minutes after the first dose was administered, the resident's Pain Assessment in Advanced Dementia (PAINAD) recorded moderate pain.

Review of the resident's records found no subsequent progress notes or PAINAD assessments completed on that day to ensure the pain interventions

were effective in relieving resident #001's pain.

Co- Director of Care (Co-DOC) #103 acknowledged that staff did not assess resident #001's response to the new treatment, to ensure the treatment was effective in relieving the resident's pain. They also said there was no indication of what action NM #101 took to relieve the resident's pain over a five hour period; nor after the resident's pain was listed as moderate, thirty minutes after receiving a new treatment for pain.

ii) On the second day at a specific time, NM # 104 documented that they applied a treatment to the same area where resident #001 had complained of pain the previous day. A PAINAD assessment was completed at a specific time and the resident was noted to have a level 2 pain, indicating continued mild pain.

Three hours later, NM #104 documented that resident #001 complained of pain to the same area; and documented that the resident's intake was poor that morning.

Later that same day, NM #105 documented that resident #001 continued to exhibit pain with movement; and had received their prescribed pain medication at the specified times, with their most recent dose being two hours prior.

Co-DOC #103 acknowledged that NM #104 and #105, did not re-assess resident #001 when it was noted the resident continued to have pain to the same area. There was also no documentation that NM #104 and #105 reassessed the resident for alternative interventions to manage the resident's pain, when the current interventions were not effective.

iii) On the third day, NM #105 documented that resident #001 continued to exhibit pain to the same area; and noted that pain medication was being administered to the resident as scheduled.

When asked what treatment or assessments were completed when resident #001 continued to complain of pain; NM #105 said they thought only the PAINAD assessment was completed.

iv) On the fourth day, Registered Nurse (RN) #108 documented that resident

#001 exhibited signs of acute discomfort, with complaints of pain and would be monitored.

According the resident's MAR, the resident received their standing dose pain medication in the morning and despite the treatment, the resident remained in pain one hour later. There was no further documentation that resident #001 was reassessed or provided alternative interventions to manage their pain, when the current interventions were not effective.

RN #108 was called to assess resident #001 for complaints of pain to the same area, but were unable to assess the area due to the resident's response and reported acuity of pain. Resident #001 was sent to hospital, however, there was no documentation that the resident was reassessed or provided with alternative pain management strategies or treatments prior to their transfer to hospital.

NM #108 said they could not recall if resident #001 was provided with additional analgesics prior to the resident's transfer to hospital, as it was not their role to administer medication. They also said their assessment of the resident was only what was documented in the progress note.

Co-DOC #103 said that no pain interventions were provided to resident #001, while the resident waited to be transferred to hospital.

Documentation indicated that while in hospital, resident #001 required further intervention to manage their discomfort associated with a diagnosed medical condition. The resident passed away while in hospital and the secondary cause of death was listed as pain resulting from the medical condition.

The licensee failed to ensure that staff complied with the home's Pain and Palliative Care policy, last reviewed May 2010; when they failed to ensure resident #001's comfort by ensuring a functional level of pain relief or pain control. The home also failed to ensure that when new pain interventions were ordered for pain control, that the effectiveness of the interventions were evaluated as soon as it was reasonable to assume the interventions would be effective. Staff failed to assess for alternative interventions to manage and control resident #001's pain, when the pain control interventions were ineffective; and this was to be an iterative process until the resident's pain was

under control as defined by the resident. [s. 8. (1) (a),s. 8. (1) (b)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one out of three residents reviewed. The home had a level 2 compliance history they had previous non-compliance related to a different subsection. (743)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2020

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (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. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with s.52 (2) of the O.Reg 79/10.

Specifically, the licensee must:

a) Ensure that when resident #003 and any other residents' pain is not relieved by initial interventions, that resident #003 and any other resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose; and that appropriate actions are taken to relieve resident #003 and any other residents' pain. The monitoring must be documented and continue until resident #003 and any other residents are no longer required to be assessed or action required to manage their pain.

b) Ensure registered staff receive education and demonstrate their understanding of the home's clinically appropriate assessment instrument specifically designed for pain. Documentation of the completed education should be kept in the home.

Grounds / Motifs :

1. The licensee 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.

A) A Complaint was submitted to the Ministry of Long-Term Care alleging that resident #001's pain was not controlled prior to their hospitalization.

Resident #001's records were reviewed in Point Click Care (PCC) and there

were multiple progress notes that documented pain or discomfort to a specific area over several days.

According to Co-DOC #104, the Comprehensive Pain Assessment located in PCC was the home's clinically appropriate assessment instrument specifically designed for pain.

On a specified date and time, resident #001 complained of pain. The pain was assessed using the PAINAD tool and was determined to be moderate pain. NP #109 assessed the resident and prescribed a specific treatment. Later that same day, NM #101 documented that resident #001 exhibited signs of acute pain, and additional pain medication was ordered.

On the second day, NM # 104 documented that treatment was provided for the resident's pain. Three hours later, NM #104 documented that the resident continued to complain of pain to the same area and had poor intake that morning. Later that night, NM #105 documented that resident #001 continued to exhibit pain.

On the third day, RPN #106 documented that treatment was administered after the resident complained of pain. Later that day, Nurse Manager #105 noted the resident continued to exhibit signs of uncontrolled pain, and pain medication was being administered as per schedule.

On the fourth day, RN#108 documented that resident #001 exhibited signs and symptoms of acute discomfort. Approximately two hours later, RN #108 assessed the resident due to continued complaints of pain to the same location, but were unable to assess the area due to the acuity of pain in the identified area.

Resident #001 was subsequently transferred to hospital, where they were diagnosed with an injury that required further interventions.

Record reviews indicated that over the several day period, there was one Comprehensive Pain Assessment initiated by RN #108 on the day resident #001 was transferred to hospital; however, the assessment was not completed until almost three months later.

RN #108 denied completing a Comprehensive Pain Assessment on the day resident #001 was transferred to hospital, and also said they had no recollection of completing the assessment three months later.

Co-DOC #103 acknowledged that staff did not assess resident #001 using the home's Comprehensive Pain Assessment, after initial interventions were not effective in relieving the resident's pain.

Resident #001 passed away while in hospital; and the resident's secondary cause of death was pain, related to a specified medical condition.

B) Resident #003 was diagnosed with an injury on a specific date. The resident had moderate to severe cognitive impairment and both Behavior Support Ontario (BSO) #110 and Co-DOC #103, said the resident would express pain through responsive behaviors.

According to PCP #113, resident #003 exhibited responsive behaviors during care one morning, which they thought was pain related.

RPN #111 documented that PCP #113 had informed them of resident #003's exhibited signs and symptoms of pain, possibly associated with an injury. RPN #111 also identified signs of injury and provided localized treatment which the resident was not compliant with.

Later that morning, NM #113 documented that RPN #114 informed them of resident #003's suspected injury; and the resident was sent to hospital that same morning, where the injury was confirmed.

Review of the resident's assessments in PCC noted that pain assessments were not completed on the morning when resident #003 exhibited signs and symptoms of pain and injury; and DOC #103 confirmed that RPN #114 did not complete the home's comprehensive pain assessment.

According to the Medication Administration Record (MAR), the resident's medication for pain was not changed or increased after the suspected injury. There were no orders for as needed (PRN) pain medication, nor was any

additional pain medication documented as being provided.

After the resident's injury, progress notes indicated that on several days, resident #003 had noted pain or discomfort, as well as responsive behaviors that were not relieved by initial interventions.

Review of the resident's records in PCC noted that resident #003 was not assessed using the home's Comprehensive Pain Assessment on the day the injury was first noted, when the resident exhibited signs and symptoms of pain and potential injury; despite continued attempts to provide local treatment. The resident was not assessed using the Comprehensive Pain Assessment over an eight day period after returning from hospital, when the resident was exhibiting responsive behaviors and signs and symptoms of pain.

According to BSO #110 and Co- DOC #103, resident #003 had frequent responsive behaviors; however, they were not able to conclusively determine that the resident was not exhibiting pain after the resident's injury.

The licensee failed to ensure that when a resident #001's pain was not relieved by initial interventions over several days, that resident #001 was assessed using a clinically appropriate assessment instrument specifically designed for pain. The licensee also failed to assess resident #003, who communicated pain through responsive behaviors, with a clinically appropriate assessment instrument specifically designed for pain, when pain was noted and when responsive behaviors were not relieved by the initial interventions. [s. 52. (2)]

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 2 compliance history as they had previous non-compliance related to a different subsection. (743)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kiyomi Kornetsky

Service Area Office /
Bureau régional de services : Central West Service Area Office