Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 15, 2015 | 2015_330573_0029 | O-002876-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD OTTAWA ON K1N 5M2

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

ANANDRAJ NATARAJAN (573), AMANDA NIXON (148), KATHLEEN SMID (161), RUZICA SUBOTIC-HOWELL (548)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): November 30, 2015, December 01,02,03,04,07,08,09 and 10, 2015.**

**Two Critical Incident Inspection logs and a Follow up inspection to a Compliance Order under Inspection #2015_286547_0002 were inspected during this inspection.**

**During the course of the inspection, the inspector(s) spoke with Residents, family members, private care givers, personal support workers (PSWs), housekeeping aides, maintenance staffs, a food service Attendant, Registered practical nurses (RPNs), Registered nurses (RNs), the President of the Residents' Council, the President Family Council, the Facilities Supervisor, the Food Services Supervisor ,the RAI-MDS Coordinator, the Manager of Hospitality Services, the Manager of Recreation, Leisure & Volunteer Services, the Manager of Personal Care, the Manager of Resident Care and the Administrator.**

**During the course of the inspection, the inspector(s) completed a walk through tour of all resident areas, observed medication storage areas, observed resident care, observed meal services, observed medication administration, reviewed resident health records, reviewed relevant home policies, protocol and procedures.**

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

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Reporting and Complaints**
**Residents' Council**
**Safe and Secure Home**
**Skin and Wound Care**

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

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2015_286547_0002 | 548 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Residents activate the home's resident-staff communication and response system by pulling on a call bell cord located in their room and in their bathroom. There is a plastic toggle attached to the end of the call bell cord for ease of use for the residents.

On November 30, 2015 it was observed that the plastic toggles at the end of 5 call bell cords were missing for Residents #002, #003, #030, #034 and #038.

On December 02, 2015 the Administrator indicated to Inspector #161 that a plastic toggle should be at the end of all call bell cords. He indicated that these cords would be fixed immediately and that the presence of a toggle would be included in all future audits of the resident-staff communication and response system. [s. 15. (2) (c)]

2. During this inspection, it was observed that the corners of the dry wall in the resident shower rooms on all the seven floors were found to be in moderate to severe damage with exposed raw porous surface and metal beneath the dry wall. It was also observed that on the sixth floor shower room, the base board on the dry wall was in disrepair for approximately two foot length. In second floor shower room, the dry wall surface had extensive damage with missing base board (approximately one foot length) exposing the gyprock. The toilet area in the spa room had disrepair in the vinyl flooring and wall surface with an open area (approximately two foot length) between the wall and the flooring exposing the sub floor. In the dry wall beside the toilet, there was missing and disrepair base board for approximately six foot length under the hand wash sink.

An interview with the home's Facilities Supervisor (FS) indicated that he is aware of many of the maintenance issues identified by Inspector. The FS further stated that he obtained a quote in 2014 for renovating the shower rooms in the home and indicated that few work order was put in the past for the above identified maintenance issues in the resident shower rooms. [s. 15. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment is maintained in a safe condition and good state of repair, specifically related to call bell cords, wall surfaces and flooring in the identified areas, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every resident's right to, have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act was fully respected and promoted.

On November 30, 2015 during lunch service in the second floor dining room at approximately 01:05pm, Inspector #573 observed the medication administration record (MAR) binder that was left 'open' on the medication cart and was unattended while registered nursing staff was feeding two residents away from the medication cart.

Information pertaining to Resident #048's allergies, diagnosis, medications and preference of how medication is to be taken was visible for approximately 25 minutes. During the time of the observation two visitors, a volunteer and another resident walked past the medication cart where the MAR information was visible.

On December 07, 2015, In the second floor dining room at approximately 12:20pm, Inspector #573 observed the medication administration record (MAR) that was observed to be left 'open' on the medication cart and was left unattended while no registered nursing staff present in the dining room. Information pertaining to Resident #049's allergies, diagnosis, medications and preference of how medication is to be taken was visible. Inspector spoke with RN S#120 in the floor who confirmed that she did not close the MAR binder before leaving the dining room.

On December 08, 2015 during an interview with the Manager of Personal Care who indicated to the inspector that the home's practice and expectation is that the registered nursing staffs are to keep residents' personal health information confidential and further indicated that the MAR binder should be kept closed in order to protect their privacy. [s. 3. (1) 11. iv.]

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**WN #3: 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 :**

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 plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

In accordance with O.Reg 79/10, s.30 and s.52, the home shall have a pain management program that includes monitoring of resident responses to and the effectiveness of pain management strategies and that policies and protocols are developed for the pain management program.

At the request of the Inspector, the Manager of Resident Care provided policy #315.18, titled Pain Assessment. The policy indicates that following the administration of a PRN analgesic or adjuvant therapy the resident will have their responses to the intervention recorded in their progress notes by registered staff.

During an interview with Inspector #148, Resident #023 indicated that there was lower back pain. In describing the pain, the resident indicated that he/she is on pain medication but that sometimes the medication does not work or only works for a short period of time.

Upon review of the resident's health care record, the resident had a fall on a specified date and begins to complain of pain in his/her back. In addition to regular pain medication, the resident is also prescribed Tylenol as needed (PRN). Due to the resident's complaints of pain, Tylenol PRN was administered five times over a period of approximately 3 months. In each of the five administrations of PRN analgesic the response to the intervention was not recorded in the progress notes. Response to the effectiveness of the Tylenol PRN administration in each instance could not be found in the health care record. [s. 8. (1) (b)]

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Garry J. Armstrong is long term care home consisting of seven floors. Floors two through seven are primarily resident home areas, whereas the first floor of the home is primarily administrative space and common areas for resident activities. On the first floor there are a set of double doors that lead to office spaces, a meeting room, staff lockers, volunteer room, exercise room and a secured door leading to a stairway.

On November 30, 2015, Inspector #161 observed the set of double doors to be unlocked. Upon a tour of the area, the Inspector observed the area and open offices to be unattended by staff. No residents were observed to be in the area.

On December 03 and 07, 2015, Inspector #148 observed the set of double doors to be unlocked. Upon a tour of the area, the Inspector observed the area and open offices to be unattended by staff. The staff lockers, exercise room and stairway door were found to be locked. No residents were observed to be in the area.

On December 07, 2015, Inspector #148 observed the set of double doors and non-residential area with the home's Administrator. It was confirmed that the double doors are equipped with a locking system that is only engaged after 04:00pm. The Administrator agreed that residents are not using the area beyond the double doors outside of attending the periodic quality improvement meeting with staff. The Administrator indicated that he would make a call to corporate security to have the lock engaged at all times.

On December 08, 2015, Inspector #148 observed the set of double doors to be locked. [s. 9. (1) 2.]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1.The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Resident #022 is usually seated in a wheelchair while in the resident's bedroom. The resident is unable to move the wheelchair around the bedroom and is reliant on staff for positioning and mobility.

On December 01, 2015, Inspector #148 observed the resident to be seated in the wheelchair while in the resident's bedroom. The wheelchair was placed near the foot of the bed, approximately two feet away from the right side of the bed. The resident-staff communication system within the bedroom consists of a panel located at the head of bed to which a string is attached. There is a face cloth tied to the end of the string which was found to be lying on the left side of the pillow at the head of bed. The resident indicated to the Inspector that the face cloth is used to pull on when the resident would like staff assistance. The resident agreed that the face cloth was not within reach. When asked by the Inspector, Resident #022 indicated that he/she would yell if assistance was needed. The Inspector than ensured the communication system was within reach by repositioning both the wheelchair and face cloth. Similar observations of Resident #022 were made on December 02, 2015, whereby the resident was in the bedroom and the communication system not within reach.

Inspector #148 spoke with PSW S#104, who is familiar with the resident's care, who indicated that the resident should have the call bell within reach. The resident's plan of care also supports that the call bell should be within reach as it relates to a history of falls. [s. 17. (1) (a)]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**19. Safety risks. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the health conditions, including pain with respect to the resident.

During an interview with Inspector #148, Resident #024 reported that he/she has pain in the right lower leg. In describing the pain, the resident indicated that pain medication is provided daily and at request. The resident's health care record indicates that the pain in the lower leg is associated with a wound which has been present for at least one year. Progress notes reviewed between September and November 2015, indicate that the resident expresses pain that prompts the administration of pain medication. The most recent Minimum Data Set (MDS) Assessment, conducted in late November 2015, indicates the resident experiences pain daily, at times the pain is excruciating.

The plan of care for Resident #024 was reviewed and does not reference the resident's pain due to the leg wound, therefore there are no goals or directions for direct care staff to assist the resident with pain management. [s. 26. (3) 10.]

2. The licensee has failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the safety risks, with respect to the resident.

Resident #022 is seated in a wheelchair for most of the day with a lap belt applied. The resident was observed on December 01, 02 and 03, 2015, to be in the resident's bedroom with the lap belt applied and unsupervised. When interviewed by Inspector #148, the resident indicated that he/she was not aware why the lap belt was in place. When asked, the resident indicated that he/she can remove the belt. The resident, with limited prompting from the Inspector due to the resident's impaired vision, was able to release the belt.

Inspector #148 spoke with PSW S#104, who is familiar with the resident's care. PSW S#104 indicated that the resident is at risk of falls and due to agitation and will sometimes attempt to leave the chair. He reported that if the belt was not in place the resident may lean forward in the chair or attempt to leave the chair whereby injury may be sustained.

The plan of care for Resident #022 was reviewed and confirms that the resident is at risk for falls. Progress notes indicate that in the past the resident has removed the belt when agitated and this has been a concern for the resident's safety. [s. 26. (3) 19.]

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.**

**Specifically failed to comply with the following:**

**s. 29. (1) Every licensee of a long-term care home,**
**(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).**
**(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.29 (1)(b), whereby the licensee did not ensure that their written policy to minimize the restraining of residents and that any restraining that is necessary is done in accordance with this Act and the regulations, is complied with.

The home's Restraints policy and procedure # 335.10 titled "Least Restraint" under Initiation of Restraint states "obtain and document consent or refusal on consent form".

A review of Resident #029's health care records on a specified date in 2011, indicated that a physician's order was obtained for the use of the lap belt restraint in the wheel chair. The use of the wheel chair lap belt restraint is also included in the Resident #029's current plan of care. However, the Resident #029's restraint consent form in the health record contain no documentation or information that Resident or Resident Substitute Decision-Maker's (SDM) consent was obtained for the use of wheel chair lap belt as a restraint.

Inspector #573 spoke with RPN S#105, who indicated that the wheel chair lap belt for Resident #29 is used as restraint. After reviewing Resident #29's progress notes, RPN S#105 indicated that on a specified date in 2011, Resident #029's SDM gave verbal consent for the use of wheel chair lap belt as a restraint and further confirmed that restraint consent was not obtained from the Resident #029's SDM using restraint consent form.

On December 04, 2015 the Manager of Personal Care (MPC) stated to Inspector #573 that before any type of restraint is initiated, the registered nursing staff would obtain consent from the resident or the Substitute Decision-Maker (SDM). The MPC further indicated to the inspector that the expectation of the registered nursing staff is to obtain and document the restraint consent for Resident #029 using the Restraint consent form as per the home's policy. [s. 29. (1) (b)]

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the restraining of the resident is included in the resident's plan of care.

Resident #015 was observed over the course of the inspection to have a lap belt applied when seated in a wheelchair. Interviews with two of the resident's sitters and with Registered Nurse S#112 indicated that the lap belt has been in place for a while and that it's purpose is to prevent the resident from leaning or sliding out of the chair and causing injury to him/herself. Inspector #148 approached the resident on two occasions, whereby the resident was unable to release the lap belt. Both of the resident's sitters and RN S#112, agreed that the resident was not able to release the belt.

Upon review of the resident health care record it was demonstrated that no consent or physician order had been obtained for the use of the lap belt. A review of the plan of care also demonstrated that the restraining of Resident #015 was not included in the resident's plan of care. [s. 31. (1)]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident #023 was observed during stage 1 activities and identified with grooming concerns. The plan of care for Resident #023 indicates that the resident requires total assistance with personal hygiene and bathing. Upon review of the bathing schedule it was determined that Resident #023 is scheduled for one shower per week. Flow sheets, used by nursing staff to document care, indicated that a shower was offered three times during the month of November, 2015.

Inspector #148 spoke with PSW S#103, who is familiar with the resident's care. PSW S#103 indicated that the resident enjoys being provided care and rarely ever refuses. Both PSW S#103 and RN S#102 indicated that it may be possible that the resident or family member may have requested only one shower a week. Inspector #148 reviewed the resident's health care record including admission information, there was no indication to explain why only one shower a week was made available to Resident #023 and no contraindications could be identified.

Inspector #148 spoke with Resident #023 on December 03, 2015, the resident was aware of the day of the week and time of day which he/she was offered the one shower a week. When asked, the resident indicated that he/she could not recall having been offered two showers a week. Upon further discussion the resident indicated that he/she would like to have two showers a week, saying that would be nice. [s. 33. (1)]

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**WN #10: 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 :**

1. The licensee has failed to 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.

During an interview with Inspector #148, Resident #023 indicated that there was lower back pain. In describing the pain, the resident indicated that he/she is on pain medication but that sometimes the medication does not work or only works for a short period of time.

Upon review of the resident's health care record, the resident had a fall on a specified date and begins to complain of pain in the lower back. At the time, the resident has regular Tylenol twice daily plus regular Tylenol as needed (PRN). Five days after the fall, due to the resident's complaints of pain and use of the Tylenol PRN, the physician orders Tylenol #1 once daily. Approximately, one month later, the Tylenol #1 is discontinued. RN S#102 describes to the Inspector, that the resident was not complaining of pain and the family preferred the resident not to be provided the narcotic. On a specified date, the physician's progress notes indicate the resident is complaining of back pain again with direction to be informed if the pain continues. Four days later, the physician orders Tylenol #1 once daily. Recently, on a specified date, the resident complains of back pain and Tylenol PRN is provided. Due to resident complaints of back pain, Tylenol PRN is also provided in the days following. Five days after the initial complaint of pain, the physician increased Tylenol #1 from once to twice daily.

The home has a Pain Assessment Tool, used to assess resident pain and is considered a clinically appropriate tool used for this purpose. In review of the health care record this tool was last completed June 30, 2015. At the time the tool was completed the resident was not experiencing lower back pain. Resident #022, has not had a pain assessment completed using the home's clinically appropriate tool, when initial pain interventions, such as the use regular Tylenol and Tylenol PRN, were ineffective to relieve pain on three occasions including post fall. [s. 52. (2)]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following:**

**s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that as part of the organized program of maintenance services, the licensee ensured that there were schedules and procedures in place for routine, preventative and remedial maintenance in relation to resident common areas in the home.

Interview of home's Facilities Supervisor (FS) indicated that he has schedules and procedures (Maintenance Audit Resident Rooms and Maintenance Request) to ensure the home is maintained in good state of repair. When inspector enquired about the schedules and procedures in place with regards to maintenance of resident common areas in relation to WN #01, The FS unable to provide any written procedures for routine, preventative and remedial maintenance related to disrepair in the resident common areas and what schedules are to be used and when. Further the FS indicated that the home do not have any schedules and procedures in place for routine, preventive and remedial maintenance for resident common areas in the home.

On December 08, 2015 Inspector spoke with the Administrator who indicated that the home has a routine schedule and procedures in place for maintenance of the resident rooms but do not have any schedules and procedures in place for routine, preventive and remedial maintenance for resident common areas in the home. [s. 90. (1) (b)]

**Issued on this 15th day of December, 2015**

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

**Original report signed by the inspector.**