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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Public Report

Report Issue Date: August 5, 2025
Inspection Number: 2025-1456-0004
Inspection Type: Proactive Compliance Inspection
Licensee: Almonte General Hospital
Long Term Care Home and City: Fairview Manor, Almonte

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8, 9, 10, 14, 15, 16, 17, 18, 22, 23, 24, 2025
The inspection occurred offsite on the following date(s): July 11, 2025
The following intake(s) were inspected:

- Intake: #00151907 - PCI

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Restraints/Personal Assistance Services Devices (PASD) Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. 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.

The licensee has failed to ensure that all doors leading to non-residential areas remain locked and secure when unsupervised by staff. Specifically, a soiled utility room door on a home area was not locked and secured despite having a keypad.

The door was immediately fixed by the home prior to the inspection concluding.

Sources: inspector observations, interview with a PSW and the Manager of Environmental Services.

Date Remedy Implemented: July 9, 2025

WRITTEN NOTIFICATION: Advice

NC #002 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 has failed to ensure to seek advice of the Residents' Council (RC) and the Family Council (FC), in carrying out the survey and acting on its results.

The satisfaction survey was sent to residents' and families in a specified date in December of 2024, without seeking advice from the Residents' Council and Family Council. The President of the Residents' Council confirmed that the home did not seek the advice in carrying out the survey or acting on its results. As well, the Chair of the Family Council indicated that they did not provide advice in carrying out the survey, and did not recall providing suggestions or advice on acting on the results.

Sources: Satisfaction Survey of Residents' and Families, RC and FC minutes, interviews with President of Residents' Council, Family Council Chair, and the Director of Care.

WRITTEN NOTIFICATION: Plan of Care-Pain

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.
Plan of care
s. 29 (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.

1) The licensee has failed to ensure that a resident's care plan included strategies for managing their pain. A resident has been taking Tylenol and Hydromorphone on a regular basis for pain but there is no indication on the care plan document to reflect any strategies to help reduce pain.

Sources: Resident's clinical records, interview with ADOC.

2) The licensee has failed to ensure that another resident's care plan document included strategies for managing their pain. A resident had been taking Tylenol on a regular basis for pain. They were prescribed Hydromorphone by injection on a specified date in July 2025 for pain. There was no focus in their care plan on how to manage the residents pain.

Sources: A resident's clinical records, and interview with the ADOC.

WRITTEN NOTIFICATION: Program Evaluations

NC #004 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.

1)The licensee has failed to conduct and keep a written record of the Skin and Wound Program evaluation.

Sources: Interview with DOC.

2) The licensee has failed to conduct and keep a written record of the homes Pain Program evaluation.

Sources: Interview with DOC.

WRITTEN NOTIFICATION: Nursing and Personal Services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (2)
Nursing and personal support services
s. 35 (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

The licensee has failed to ensure that there is a written staffing plan for the organized nursing and personal support services.

Sources: Corporate staffing plan and scheduling of staff policy, interviews with the scheduling coordinator, ADOC, and DOC.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 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.

1) The licensee has failed to comply with the Skin and wound program when the home's registered staff did not update a resident's care plan identifying strategies and interventions for healing of a two wounds. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the skin and wound management program were complied with. Specifically, the home's skin and wound policy, titled " Wound and Skin Care Management Protocol", indicated that registered staff are to ensure all interventions are listed in the residents care plan.

Sources: A resident's clinical chart, Homes "Wound and skin Care Management Protocol, and interviews with the skin and wound lead and the ADOC.

2) The licensee has failed to comply with the Skin and wound program when the home's registered staff did not update a second resident's care plan identifying

strategies and interventions for healing of three wounds. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the skin and wound management program were complied with. Specifically, the home's skin and wound policy, titled " Wound and Skin Care Management Protocol", indicated that registered staff are to ensure all interventions are listed in the residents care plan.

Sources: A resident's clinical chart, Homes "Wound and skin Care Management Protocol, and interviews with the skin and wound lead and the ADOC.

WRITTEN NOTIFICATION: Skin and Wound

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (c)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure injuries, skin tears or wounds and promote healing;

The licensee has failed to ensure that residents who require equipment, supplies, devices and positioning aids for aiding in the prevention and healing of wounds, have these items readily available in the home and do not charge residents for any of these items. Specifically, a resident, was charged for protective skin care supplies to promote healing and protect them from further skin breakdown. Other residents have also been charged for items such as protective booties as identified by the skin and wound lead and the Occupational Therapist (OT).

Sources: A resident's progress notes and interview with the skin and wound lead,

OT, and the ADOC

WRITTEN NOTIFICATION: Pain-Monitoring

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

1) The licensee has failed to ensure that monitoring of the effectiveness of regularly scheduled pain medications given to a resident has been documented. A resident was prescribed hydromorphone on a specified date in July 2025 and Tylenol regularly for pain management regarding their palliative status and there has been no documentation of the effectiveness of the pain medications since it was prescribed.

Sources: A resident's clinical records, interview with ADOC

2) The licensee has failed to ensure that monitoring of the effectiveness of pain medications given to another resident has been documented. A resident was prescribed hydromorphone in February 2025 for pain management of significant nature and there has been no documentation of the effectiveness of the pain medications since it was prescribed.

Sources: Resident's clinical record, interview with ADOC.

WRITTEN NOTIFICATION: Chemicals not secured on housekeeping cart.

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that a hazardous substance specifically, a "Blue Force" toilet bowl cleaning product was always kept inaccessible to residents.

On a specified date in July 2025, a housekeeping cart on a specified unit was unlocked in the corridor and had a bottle of "Blue Force" toilet bowl cleaning product accessible to residents. This chemical has a danger symbol that indicates the product may cause severe burns or eye damage and recommends the use of protective equipment of chemical resistant gloves, and eye protection.

Sources: Inspector observations, interviews with a PSW, Housekeeper, and Environmental Services Manager.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2)

Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any.

The licensee has failed to ensure that one member of the Residents' Council (RC) and one member of the Family Council (FC), were members of the Continuous Quality Improvement (CQI) committee.

A discussion was held with the Director of Care (DOC) on a specified date in July 2025, where they indicated that a resident and family member were not part of the home's Continuous Quality Improvement (CQI) committee, as it is currently joined with the hospital. An interview conducted with the President of the Residents' Council also confirmed that they were not part of the CQI committee.

Sources: interviews conducted with the Director of Care and President of Residents'

Council.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 1.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
1. The name and position of the designated lead for the continuous quality improvement initiative.

The licensee has failed to ensure that the name and position of the designated lead for the Continuous Quality Improvement (CQI) initiative for the home is included in the 2024-2025 Continuous Quality Improvement (CQI) report posted on the home's public website.

Sources: Fairview Manor Continuous Quality Improvement (CQI) initiative report posted on the home's public website.

WRITTEN NOTIFICATION: Continuous Quality Improvement initiative report.

NC #012 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 has failed to ensure that the 2024-2025 Continuous Quality Improvement (CQI) initiative report posted on their public website, included the dates and how the results of their resident and family/caregiver experience surveys taken during the fiscal year of 2024 were communicated to the residents' and their families, Residents' Council, Family Council, and members of the staff of the home.

Sources: Fairview Manor 2024-2025 Continuous Quality Improvement (CQI) initiative report posted on the home's public website.

WRITTEN NOTIFICATION: Continuous Quality Initiative report.

NC #013 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 outcomes of the actions taken to improve the

long-term care home, and the care, services, program and goods based on the documentation of the results of the resident and family/caregiver experience survey were included in the home's 2024-2025 Continuous Quality Improvement (CQI) initiative report.

Sources: Fairview Manor 2024-2025 Continuous Quality Improvement (CQI) initiative report posted on home's website.

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 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee failed to provide a copy of the Continuous Quality Improvement (CQI) initiative report for the fiscal year of 2024.
Sources: Residents' and Family Council meeting minutes, and interviews with President of Resident Council and Chair of Family Council.

COMPLIANCE ORDER CO #001 PASDs that limit or inhibit movement

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 36 (4)
PASDs that limit or inhibit movement

s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.Within seven days of receipt of this compliance order, the Administrator or a designated manager will complete a visual audit for all residents residing in the home to determine which residents have a PASD in place, specifically bed rails.

Upon completion of the PASD audit, the administrator or designate manager will ensure all residents residing in the home who have a PASD in place meet the

legislative requirements. Specifically, the home will complete the following:

-Document in every resident's chart progress notes and care plan alternatives that were considered and trialed with a detailed outcome of effectiveness and reasoning for the use of the PASD, specifically bed rails, as required. The consideration, trial and outcome should be held and discussed at an interdisciplinary level, involving the resident and/or Substitute Decision Maker.
-The home will develop a formal process for approval for the use of a PASD. The process will be outlined who is responsible, who will provide the approval, how the approval will be obtained, where it will be documented and kept, and who is notified of the approval and how.
-The home will obtain consent for use of all PASD's in the home from the resident or SDM.
-The home will update every resident's care plan for the use of of the PASD, specifically bed rails, including but not limited to the following: type of PASD being used, , to support what specific activity of daily living, and when it should be used (time of day, duration etc.), how often it should be monitored and any other guiding parameters for the use of the PASD.

2.The Administrator or designate manager will develop and implement a process where by the resident is assessed for the use of the PASD, at minimum, with any change of status whereby the PASD is removed as soon as it is no longer required to provide assistance with routine activities of living.

3.The Administrator or designate manager will provide education to all registered staff, both RPN's and RN's, on the use of PASD's, specifically bedrails and the requirements that must be in place in the resident plan of care so that they may be used.

4.The licensee must email the inspector and the inspector's manager by September 12, 2025, with an update with details regarding the progress toward completion the licensee has made for this order.

5.Written records for items one through four will be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure when the use of a personal assistance service device (PASD) is used to assist a resident with a routine activity of daily living, that alternatives to the use of PASD have been considered, is approved by a regulated professional of the home, and consent obtained by resident or substitute decision maker (SDM).

Specifically, on a specified date in July 2025, observations made by the inspector, showed that all residents in the home had bedrails which the Assistant Director of Care (ADOC) indicated were being used by the residents as a personal assistive service devices (PASD).

On this same day, after review of two resident's health records, no PASD alternative checklist was completed as per home's policy, PASD Policy VII F-10.9, reviewed May 2024. A resident's health record had no consent on record for the use of bed rails as a PASD. As well, several other charts were reviewed in the presence of ADOC, and there was no clear documentation to indicate who approved the initiation of bedrails as a PASD to support the residents and for what aspect in their activities of daily living.

Further review of a resident's written plan of care, indicates the use of bed rails as a

PASD for bed mobility, yet the written order indicates that the resident is using bed rails as a PASD to support positioning while in bed. An interview conducted with a PSW, on a specified date in July 2025, indicates that the resident cannot participate in bed mobility; that the bed rails are not for positioning, they are being used for safety. Another interview was conducted on a specified date in July 2025 with an RPN, who indicated that bed rails were being used as a PASD for the resident to support positioning to prevent the resident from falling out of bed.

As well an interview was conducted on a specified date in July 2025, with another RPN, whom indicated that most residents on a specified unit used bedrails and that no assessments, consultations or consents were required for their use because the bed rails were not restraints.

Sources: resident health records, PASD Policy VII F-10.9, reviewed May 2024, and interviews with a PSW, RPN's, and the ADOC.

This order must be complied with by October 31, 2025

COMPLIANCE ORDER CO #002 Bed rails

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 18 (1)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all

potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The licensee shall develop and implement a program to ensure that where bed rails are used, the resident is assessed in accordance with the prevailing practices outlined in the following document: "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, April 2003" (the Clinical Guidance document). The program is to encompass all aspects of the Clinical Guidance document including the guiding principles, policy considerations, the process/procedure considerations, risk interventions, etc.

a) Within seven business days of receiving this Compliance Order, the interdisciplinary team members as prescribed must be designated and provided with orientation training with regards to the Clinical Guidance document and their roles and responsibilities as team members.

b) All current residents using bedrails must be assessed as prescribed. Decisions to continue or discontinue usage shall be made by the interdisciplinary team(s) based on the assessments and evaluation of the relative risk of using bed rails compared to not using them for a resident. Consideration of risk includes the risk of injury or death related to the entrapment zones on the resident's bed system. Documentation must include the risk benefit assessment and all other stated requirements in the Clinical Guidance document.

c) All new residents to be assessed in accordance with the new program upon

admission.

2. The licensee shall develop and implement a program to ensure that where bed rails are used, the resident's bed system is evaluated in accordance with the prevailing practices outlined in the following document: "Guidance Document – Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008" (the Guidance document). The program must include, but is not limited to:

a) Evaluation of all bed systems with bed rails on them as per the Guidance document within eighteen business days of receiving this Compliance Order. If an entrapment zone fails the prescribed test, immediate action must be taken to eliminate the identified risk in collaboration with the team as referenced in part 1 of this order.

b) Staff responsible for conducting bed system evaluations must receive training and ongoing support. Their competency must be verified to ensure evaluation are performed in accordance with the Guidance document including correct use of the testing tool and accurate documentation of results.

c) Where mattresses subject to testing exclusions under the Guidance document are in use (e.g., certain types of air mattresses), additional measures must be implemented to prevent resident entrapment. The team referenced in Part 1 of this order must assess and document their determination that the therapeutic benefit of using the mattress outweighs the associated entrapment risk. Noting a "pass" for entrapment zones on a bed system with such a mattress with no further actions is not acceptable.

d) A detailed inventory of all bed systems with rails to be developed and maintained

by September 2, 2025 of receiving this Compliance Order. Records must include evaluation information and results such as identifying information for the bed deck, mattress, rail type, rail positions (e.g. rotating rail in the up and or in the down position), condition of rail with corrective action as required, entrapment zone testing and results. All bed system components must be traceable. Information about mattress compatibility must be clearly and permanently marked on the bed.

e) Reassessment of bed systems at regular intervals such as annually to account for the effects of aging components (e.g., a softening mattress may result in a zone 3 failure) and any time a new bed system is created due to changes or replacement of components including mattresses, bed frames or rails.

3. Education for all nursing staff about the new bed safety program, including orientation to the identified entrapment zones on a bed system and consideration of the different types of rails in use throughout the home (e.g. rotating rails can be used in the up and in the down position, entrapment zones differ accordingly), key body parts at risk for entrapment, entrapment zone testing methods in general, assessment of residents for risk of entrapment within the bed system in general.

4. Document and keep a record of the education provided, including topics covered, the names of the staff in attendance, date, and who provided the education.

5. The licensee must email the inspector and the inspector's manager by September 12, 2025, with an update with details regarding the progress toward completion the licensee has made for this order.

6. Written records for items one through five will be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that where bedrails are used, the resident is assessed, and the resident's bed system is evaluated, according to prevailing practices.
Direction from the Ministry to Long- Term Care Homes in the form of a 2023 memo titled "Ministry of Long-Term Care Guidance Document, Use of Bed Rails in Long-Term Care Settings, updated August 2023" identified the prevailing practice documents that were applicable to bed rails use. Over the course of the inspection, it was determined that bed rail use was not in accordance with the identified prevailing practice documents.

Specifically, on a specified date in July, 2025, the Inspector, and Assistant Director of Care (ADOC), observed every bed in the home and identified that all beds had bed rails attached to the bed system, including two vacant beds. During this observation five different styles of bed rails were in use.

The home's policy titled, Bed rails & Pads, Resident Care-VII-G-10.34, last reviewed June 2014, was not aligned with prevailing practices, or requirements with the use of bed rails.

An interview on the same day with the ADOC, revealed that residents had not been assessed, nor had a bed entrapment audit been conducted on these beds. The Director of Care (DOC) also confirmed during an interview conducted on a specified date in July 2025, that bed system evaluations for beds with bed rails has not been completed.

Sources: observations, Bed rails and Pads, Resident Care-VII-G-10.34, Ministry Of Long-Term Care Guidance Document: Use of Bed Rails in Long-Term Care Settings,

updated 2023, and interviews with the Assistant Director of Care (ADOC) and Director of Care (DOC).

This order must be complied with by October 31, 2025

COMPLIANCE ORDER CO #003 Required programs

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
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:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

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

B) Educate all registered staff, both registered practical nurses (RPN's) and Registered Nurses (RN's) on the pain management policy ensuring education is provided on documenting pain levels and effectiveness of pain medications given and pain assessments.

C) Perform weekly audits on two random residents receiving medications for pain management and ensure pain levels; effectiveness of pain medications and assessments are completed. Audits are to be conducted until consistent compliance to the Pain program is demonstrated.

D) Take corrective actions to address staff non-compliance related to pain management at the time of the audit and document.

E) Ensure that pain management strategies and interventions are added to all residents plan of care who receive pain medications to manage pain.

F) Written records, which will include the date the policy went in to effect, the date the education was provided and by whom, of A, B, C, D and E, shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to implement their updated pain management program in the home.

During a review of a resident's clinical chart, there were no documented pain assessments ever completed from the time of a resident's admission to the home in April of 2024. Their electronic medication administration record (eMAR), indicated they were on two types of pain medication, which consisted of Tylenol 325 mg, and Hydromorphone 0.5 mg. There was no indication as to why the resident was receiving these medications. The resident has a CPS score of 4, which indicated cognitive impairment, and thus may not be able to verbalize whether they are in pain or not. Further review of residents eMAR, did not indicate the residents pain level prior to the administration of the pain medications noted above, nor was the effectiveness of the pain medication documented. The resident's care plan, did not have any indication that the resident had any pain as a focus, and no strategies or interventions noted to alleviate pain using alternative methods or pain medications.

During a review of the homes pain management program policy titled, "Pain and Symptom Management" last updated in April 2025, indicated that residents are to be assessed for pain, on admission, quarterly and as needed for any residents experiencing pain and that an appropriate assessment tool is to be used in Point Click care. It further indicated that effectiveness of pain medications are to be documented in point click care, and to include interventions related to assessed pain and symptom management in the plan of care.

During an interview with the ADOC on a specified date in July 2025 at a specified time, they confirmed that the pain program policy has been recently updated, but has not been implemented as of yet, and that a clinically approved pain assessment, such as PAINAD, is to be used for assessing pain. They also confirmed that registered staff are to document the effectiveness of the pain medication given and to document interventions on the residents care plan. That a focus of pain should be on the care plan.
During an interview with the DOC on a specified date in July 2025 at a specified time they confirmed that the pain program policy has been updated, but has not been implemented yet.

Sources: A resident's clinical file, homes pain management program policy, titles, "Pain and Symptom Management", interviews with the ADOC and DOC.

This order must be complied with by October 31, 2025

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.