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

**London District**
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

# Amended Public Report Cover Sheet (A1)

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|---|---|
| **Report Issue Date:** June 5, 2023 | |
| **Inspection Number:** 2023-1461-0005 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident System | |
| **Licensee:** Schlegel Villages Inc. | |
| **Long Term Care Home and City:** The Village of Glendale Crossing, London | |
| **Lead Inspector**<br>Melanie Northey (563) | **Inspector Digital Signature**<br>Melanie Northey Digitally signed by Melanie Northey Date: 2023.06.05 13:04:48 -04'00' |
| **Additional Inspector(s)**<br>Peter Hannaberg (721821) | |

## AMENDED INSPECTION SUMMARY

This report has been amended to:
Correct Compliance Order #001 Duty to Protect

e) Ensure the Registered Nurse receives training related to policies and procedures for the changing and care of catheters.

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**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

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London, ON, N6A 5R2
Telephone: (800) 663-3775

# Amended Licensee Report (A1)

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|---|---|
| **Amended Report Issue Date:** June 1, 2023 | |
| **Original Report Issue Date:** May 31, 2023 | |
| **Inspection Number:** 2023-1461-0005 (A1) | |
| **Inspection Type:**<br>Complaint<br>Critical Incident System | |
| **Licensee:** Schlegel Villages Inc. | |
| **Long Term Care Home and City:** The Village of Glendale Crossing, London | |
| **Lead Inspector**<br>Melanie Northey (563) | **Additional Inspector(s)**<br>Peter Hannaberg (721821) |
| **Amended By**<br>Melanie Northey (563) | **Inspector who Amended Digital Signature**<br>Melanie Northey Digitally signed by Melanie Northey Date: 2023.06.05 13:05:14 -04'00' |

## AMENDED INSPECTION SUMMARY

This report has been amended to:
Correct Compliance Order #001 Duty to Protect
e) Ensure the Registered Nurse receives training related to policies and procedures for the changing and care of catheters.

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2-5, and 8-11, 2023 with May 2, 2023 conducted both on-site and off-site.

The following complaint intake(s) were inspected:

- Intake #00087049 was related to pain management;
- Intake #00084243 was related to multiple care concerns and falls prevention and management; and
- Intake #00020032 and intake #00084593 were related to continence care.

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The following critical incident (CI) intake(s) were inspected:

- Intake #00020837 / CI #2979-000020-23 was related to falls prevention and management; and
- Intake #00022667 / CI #2979-000041-23 and intake #00084407 / CI #2979-000043-23 were related to continence care.

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

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Residents' Bill of Rights

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee has failed to ensure that a resident's right to services consistent with their needs related to laboratory services was fully respected and promoted.

**Rationale and Summary**
A complaint was reported to the Ministry of Long-Term Care by a family member of a resident indicating that the resident did not receive the required laboratory services ordered by the physician until several weeks later.

Review of progress notes, the prescriber order forms, and the laboratory confirmation service forms, verified the resident did not receive the required laboratory services ordered by the physician until several weeks later. There were multiple flagged test results outside the reference range.

The Director of Care (DOC) stated the management team recognized that the night nursing team members were not faxing the confirmation forms for onsite lab services on time to the laboratory service provider, and that the home had night agency registered staff working at that time who were not following routine procedures.

The lab tests were delayed putting the resident at potential risk for delayed treatment and follow up. From the time of the first prescriber's order for laboratory services to the time of additional supportive laboratory services rendered, a month had passed since the time of the reported concerns.

**Sources:** clinical record review for the resident, review of laboratory forms; and family and staff interviews. [563]

## WRITTEN NOTIFICATION: Plan of Care

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

The licensee failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

**Rationale and Summary**
The electronic Medication Administration Record (eMAR) for a resident documented specific directions related to the monitoring and assessment of pain, and the administration of pain medication.

The Director of Care (DOC) verified the three orders to assess for pain and provide pain medication were unclear. A Registered Practical Nurse had difficulty explaining the intent and expectation for documentation related to the direction to assess pain and the administration of pain medication.

The resident was at risk for not receiving adequate pain management and assessments as required since the directions for the pain assessment and medication administration were unclear.

**Sources:** clinical record review for the resident, and staff interviews. [563]

## WRITTEN NOTIFICATION: Orientation

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 82 (2) 1.

The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the Residents' Bill of Rights.

**Rationale and Summary**
Fixing Long-Term Care Act (FLTCA) s. 82 (1) states, "Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section."

Ontario Regulation (O. Reg) 246/22, s. 259 (3) states, "Subsection 82 (3) of the Act does not apply during a pandemic, and instead, the training required under section 82 of the Act must be provided,
(a) within one week of when the person begins performing their responsibilities, with respect to the matters set out in paragraphs 1, 3, 4, 7, 8 and 9 of subsection 82 (2) of the Act.

The record for mandatory training for a Personal Support Worker (PSW) documented the completion of training for "Resident Rights in Long-Term Care" was not received within one week of the PSW performing their responsibilities and the DOC verified it was not completed within one week.

**Sources:** review if the record for mandatory training, and staff interviews. [563]

## WRITTEN NOTIFICATION: Orientation

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 82 (2) 3.

The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the home's policy to promote zero tolerance of abuse and neglect of residents.

**Rationale and Summary**
Fixing Long-Term Care Act (FLTCA) s. 82 (1) states, "Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section."

Ontario Regulation (O. Reg) 246/22, s. 259 (3) states, "Subsection 82 (3) of the Act does not apply during a pandemic, and instead, the training required under section 82 of the Act must be provided,
(a) within one week of when the person begins performing their responsibilities, with respect to the matters set out in paragraphs 1, 3, 4, 7, 8 and 9 of subsection 82 (2) of the Act."

The record for mandatory training for a Personal Support Worker (PSW) documented the completion of training for "Preventing, Recognizing and Reporting Abuse and Neglect in LTC" was not received within one week of the PSW performing their responsibilities and the DOC verified it was not completed within one week.

**Sources:** review if the record for mandatory training, and staff interviews. [563]

## WRITTEN NOTIFICATION: Orientation

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 82 (2) 4.

The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the duty to make mandatory reports.

**Rationale and Summary**
Fixing Long-Term Care Act (FLTCA) s. 82 (1) states, "Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section."

Ontario Regulation (O. Reg) 246/22, s. 259 (3) states, "Subsection 82 (3) of the Act does not apply during a pandemic, and instead, the training required under section 82 of the Act must be provided,
(a) within one week of when the person begins performing their responsibilities, with respect to the matters set out in paragraphs 1, 3, 4, 7, 8 and 9 of subsection 82 (2) of the Act."

The record for mandatory training for a Personal Support Worker (PSW) documented the completion of training for "Mandatory Reporting" was not received within one week of the PSW performing their responsibilities and the DOC verified it was not completed within one week.

**Sources:** review if the record for mandatory training, and staff interviews. [563]

## WRITTEN NOTIFICATION: Required programs

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

The licensee failed to ensure that the interdisciplinary pain management program to identify and manage pain in residents was developed and implemented in the home.

**Rationale and Summary**
Ontario Regulation 246/22, s. 11. (1) b states, "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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with."

Ontario Regulation 246/22, s. 34 (1) states, "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:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

Specifically, staff did not comply with the licensee's Pain Management Program Policy and the Medications Policy which was part of the licensee's pain management program.

Schlegel Villages Pain Management Program Policy identified the use of a Pain Assessment which contains two different formats based on the resident's ability to communicate:

- Pain Assessment in Advanced Dementia Scale (PAINAD) used with residents who cannot communicate pain or who have cognitive impairment.
- Numeric Scale (0-10) used for residents able to verbalize type, location, and intensity of pain.

A) A resident was documented as part of the progress notes as having difficulty verbalizing pain. The electronic Medication Administration Record documented a numeric pain level by the Registered Practical Nurse (RPN). The RPN stated the resident did not report pain but exhibited expressions without describing a pain scale. The RPN stated they would provide a pain scale

depending on what personal expressions were observed and verified the expressions observed to assess pain were not documented.

The medications policy documented the effectiveness/outcome of the administered [as needed] pain medication was to be documented after the medication has had sufficient time to act.

The Director of Care (DOC) stated the expectation was for the registered nursing staff to document the effectiveness of the administered “as needed” pain medication in the progress notes. The resident had effectiveness documented several hours after an “as needed” pain medication was administered on multiple dates. The DOC stated this was unreasonable and the registered nursing staff should have followed up within an hour. The DOC verified the resident could have been in unresolved pain or a higher pain level for a time frame of three to five hours.

B) While reviewing a second resident's plan of care, the physician ordered the PAINAD pain assessment tool be used to assess the resident's pain level when they changed their pain medication. The assessments were completed, and multiple times the registered nursing staff used the numerical scale to assess pain.

The DOC stated that the resident required use of the PAINAD scale due to their level of cognition and inability to accurately self-describe their level of pain.

The resident was at risk for having unmanaged pain when they were not assessed using the appropriate tool.

**Sources**: resident's pain assessments, observations and interviews with the resident, review of policies, and staff interviews. [563] [721821]

## WRITTEN NOTIFICATION: Continence Care and Bowel Management

**NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)

The licensee failed to ensure that a resident, who was incontinent, received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

**Rationale and Summary**
A resident had the Continence Evaluation completed; however, the evaluation did not include the resident's functional assessment related to their medical history, relevant diagnosis, bladder assessment for level of continence, causal factors, patterns, type of incontinence, and potential to restore function with specific interventions.

The resident's assessment identified incontinence and the Director of Care verified the resident did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions since the registered staff member did not complete the Continence Evaluation. The nursing support staff caring for the continence needs of the resident rely on a plan of care that should be based on an assessment of the resident's needs. The Continence Evaluation assessment was incomplete, and a Bowel and Bladder Assessment was not completed.

**Sources:** clinical record review for a resident and staff interviews. [563]

## WRITTEN NOTIFICATION: Pain Management

**NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

**Rationale and Summary**
The Director of Care (DOC) and Assistant DOC verified the clinically appropriate assessment instrument specifically designed for assessing pain was the Pain Assessment.

There was a medical directive for the administration of pain management medication as needed for a resident. The medication was administered to the resident was documented as ineffective. The DOC verified there was no clinical follow up and no documentation that a pain assessment was completed when pain was unrelieved.

The Pain Management Program documented that the registered team were to conduct a pain assessment when pain remained regardless of the support strategies. The resident was not assessed using the Pain Assessment when pain was not relieved by initial interventions and put the resident at risk for unresolved discomfort.

**Sources:** clinical record review for a resident, review of the Pain Management Program; and resident and staff interviews. [563]

## WRITTEN NOTIFICATION: Dealing with Complaints

**NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee failed to ensure that a documented record was kept in the home that included the nature of each verbal complaint made to a staff member concerning the care of a resident.

**Rationale and Summary**
Ontario Regulation 246/22, s. 108 (1) states, "Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with".

The Ministry of Long-Term Care received a complaint reporting multiple care concerns for a resident related to the breakdown in communication between nursing staff and management in the home. The complainant specifically stated there were concerns related to the possible link between inconsistent care and the resident's recurrent negative clinical outcomes.

A progress note documented the resident's family member was notified of a health change related to a new medication order. The note documented a family member was concerned about the possibility of another care concern that could lead to a negative clinical outcome and that the nurse would pass on their concerns.

The Administrator verified the verbal complaint related to the care of a resident was not passed to the nursing management team for appropriate follow up and action and there was no documented record of the complaint.

**Sources:** clinical record review for a resident, review of the Complaint Response Forms and the Complaints Procedure Policy; and family and staff interviews. [563]

## COMPLIANCE ORDER CO #001 Duty to protect

**NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

The Licensee has failed to comply with FLTCA, 2021, s. 24 (1).
Specifically, the licensee must:
a) Ensure the order to change the clinical intervention for the resident is documented as part of the electronic administration record in Point Click Care.
b) Ensure the clinical intervention for the resident is changed according to the physician's order.
c) Ensure a resident receives an assessment that includes identification of causal factors, patterns, type of incontinence, and potential to restore function with specific interventions using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.
d) Ensure the clinical intervention for another resident is changed according to the physician's order.
e) Ensure the Registered Nurse receives training related to policies and procedures for the changing and care of the specific clinical intervention.
f) Ensure there is a written record of the training provided, who provided the training, the date it was provided, and who attended.

**Grounds**
The licensee failed to protect residents from neglect by the registered nursing staff.

For the purposes of the Act and this Regulation, “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

**Rationale and Summary**
A) A Critical Incident System (CIS) report documented a resident’s order for a specific clinical intervention, to be completed monthly, was mistakenly discontinued. The full-time Registered Practical Nurse (RPN) stated that upon their return to work and noticed that there was no order for the clinical intervention and realized that the resident's care related to the specific clinical intervention was not provided for several months.

There was no order for the clinical intervention as part of the clinical record for the resident for several months.

The clinical intervention was then provided to the resident, and the resident had a negative medical outcome and was transferred and admitted to acute care for further assessment and treatment.

The Director of Care (DOC) stated there was no documentation to indicate the specific clinical intervention, to be completed monthly, was provided for eight months. The Administrator stated there was a lack of routine registered staff with no consistency.

The registered nursing staff failed to provide the resident with the care and assistance required for health, safety or well-being, and included a pattern of inaction that jeopardized their health, safety or well-being when the specific clinical intervention for the resident was not provided monthly for eight months. In that time the resident was transferred to hospital on multiple occasions for related health concerns.

B) A Critical Incident System (CIS) report documented the improper/incompetent treatment of a resident that resulted in harm during the provision of a specific clinical intervention that resulted in a negative clinical outcome and significant risk to the resident.

The investigation concluded that the registered nursing team members did not perform the specific clinical intervention appropriately. The resident was transferred and admitted to acute care for further assessment and treatment.

The DOC verified the resident was not monitored appropriately after the specific clinical intervention was performed, and the resident had a negative clinical outcome.

The registered nursing staff failed to provide the resident with the care and assistance required for health, safety or well-being, and included a pattern of inaction that jeopardized their health, safety or well-being when the specific clinical intervention for the resident was provided and caused a negative clinical outcome.

**Sources:** clinical record review for the residents, review of program policies, review of investigation notes, and interviews with staff, and interviews with staff. [563]

**This order must be complied with by** June 16, 2023

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #001**
**Related to Compliance Order CO #001**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice. In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

**Compliance History:**
CO #001 on January 6, 2021 for inspection #2021_788721_0018 (A3) under LTCHA, 2007, s. 19 (1).

This is the first time the licensee has failed to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## COMPLIANCE ORDER CO #002 Dining and Snack Service

**NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

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

The Licensee has failed to comply with O. Reg. 246/22, s. 79 (1) 8.
Specifically, the licensee must:
a) Provide safe dining strategy training to a specific Personal Support Worker (PSW) and all other PSWs working in a specific neighbourhood.
b) Ensure there is a written record of the training provided, who provided the training, the date

it was provided, and who attended.
c) Ensure the plan of care for a resident related to eating and nutrition is provided to the resident as planned to safely eat and drink as comfortably and independently as possible.
d) Ensure observations are completed in the dining room of the resident during a breakfast, lunch, and dinner meal service on random days until compliance is achieved.
e) Ensure there is a written record of the observation, date of the observation, and the name of the person who conducted the observation. Document any discrepancies between plan of care for eating and nutrition and the care provided, and document the immediate action taken if any discrepancies are discovered.

**Grounds**
The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, providing the resident with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

**Rationale and Summary**
A Personal Support Worker (PSW) was observed in the dining room during the breakfast meal service providing total feeding assistance to a resident. PSW was observed feeding resident with a tablespoon heaped with food. The resident was moving their mouth in a chewing motion while the PSW was attempting to put more food in the resident's mouth. When the resident did not respond by opening their mouth, the PSW repeatedly poked the resident’s mouth with a full tablespoon of food. The resident was observed to be pulling their head back, away from the spoon. Inspector intervened immediately and approached the dining table. Inspector asked PSW to stop feeding the resident by forcing food into their mouth while the resident was still chewing because the resident could choke. A second inspector continued observing the PSW while managers were sought out for follow up.

A second inspector observed the PSW forcefully feeding the resident after being spoken to directly to say feeding a resident that way was inappropriate. The PSW continued to put large amounts of food on the tablespoon sized spoon into the resident's mouth while they appeared to be trying to chew and swallow the food that was already in their mouth. PSW was not observed to be checking for pocketing of food after the resident had swallowed per the care plan instructions. The pace of the feeding assistance appeared rushed, as the resident was pulling their head away while they were still chewing and swallowing, but the next spoonful of food was already being held by the PSW near the resident's mouth and occasionally touching their lips.

The PSW stated they were not familiar with the resident and that they had not worked in the specific neighbourhood before. Inspector explained that food was being pressed against the resident's mouth while they were already eating, and the assistance to eat safely and at the resident's own pace to prevent choking and aspiration risk was not provided. The PSW did not express the insight or acknowledgement of the potential risk of choking and aspiration.

The resident's care plan documented multiple strategies to reduce the risk of choking and aspiration.

The General Manager verified the resident was not provided the care as planned and the PSW did not provide the assistance and encouragement required for the resident to safely eat as comfortably and as safely as possible at their own pace.

**Sources:** Clinical record review for the resident, review of the Supportive Dining Training materials, observation of the resident and staff interviews. [563]

**This order must be complied with by** June 16, 2023

## COMPLIANCE ORDER CO #003 Administration of Drugs

**NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

The Licensee has failed to comply with O. Reg. 246/22, s. 140 (2)
Specifically, the licensee must:
a) Ensure that pain management medications are administered to the resident in accordance with the directions for use specified by the prescriber.
b) Ensure the effectiveness of pain management medications are documented within an hour of an "as needed" pain medication to determine drug effectiveness and complete a clinically appropriate assessment instrument specifically designed to assess pain when initial interventions are ineffective.
c) Ensure the plan of care related to the administration of medications, monitoring, and assessment of pain for the resident provides clear direction to staff and others who provide direct pain management to the resident.
d) Ensure Registered Practical Nurses and Registered Nurses assigned to monitor, assess, and

administer medications to the resident receive training on pain management policies and procedures.
e) Ensure there is a written record of the training provided, who provided the training, the date it was provided, and who attended.

**Grounds**
The licensee failed to ensure that pain management drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

**Rationale and Summary**
The resident had a physician's order for a medical directive for the administration of pain management medication as needed.

Administration progress notes documented the pain medication was administered and the Registered Practical Nurse (RPN) documented the medication was ineffective. The administration of the pain medication was assessed for effectiveness over 8 hours later and the resident should have been offered additional pain medication every four hours as needed. A family member was visiting the resident and reported that the resident was experiencing pain and no pain medication was administered to address the discomfort. The Director of Care (DOC) verified the resident was not administered pain medication according to the directions specified every four hours as needed.

The resident had documented pain on multiple dates and times and was not administered the pain medication as prescribed, and several hours after pain was identified as greater than zero. The DOC verified there was no documentation to identify the cause and type of pain when the severity was documented as greater than zero. The DOC stated the registered nursing staff should have followed up within an hour of an "as needed" pain medication to determine drug effectiveness and should have completed a pain assessment when ineffective.

The resident was at risk for unresolved pain or a higher pain level when medication effectiveness was not assessed until hours later. The DOC stated if the drug effectiveness was documented as "unknown", it should be accompanied by a progress note explaining why.

**Sources:** clinical record review for a resident, family and resident interview, and staff interviews. [563]

**This order must be complied with by** June 16, 2023

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #002**
**Related to Compliance Order CO #003**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice. In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

**Compliance History:**
CO #001 on March 10, 2022 for inspection #2022-979740-0007 under O. Reg. 79/10 s. 131. (2).

This is the first time the licensee has failed to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## 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.