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)

Amended Report Issue Date: April 17, 2023
Original Report Issue Date: March 15, 2023
Inspection Number: 2023-1474-0004 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village at St. Clair,Windsor

Amended By	**Director who Amended Digital Signature**
Cassandra Taylor (725)	Cassandra L Taylor Digitally signed by Cassandra L Taylor Date: 2023.04.17 12:28:24 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This licensee inspection report has been revised to reflect an extension for the compliance due date for CO #001, from May 15, 2023, to June 15, 2023. The inspection #2023_1474_0004 was completed on January 30 – 31, February 2, 6-10, 13-16, 27-28, 2023.

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Lead Inspector Cassandra Taylor (725)	**Additional Inspector(s)** Debra Churcher (670) Peter Hannaberg (721821)
Amended By Cassandra Taylor (725)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

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This licensee inspection report has been revised to reflect an extension for the compliance due date for CO #001, from May 15, 2023, to June 15, 2023. The inspection #2023_1474_0004 was completed on January 30 – 31, February 2, 6-10, 13-16, 27-28, 2023.

Original Public Report

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Lead Inspector Cassandra Taylor (725)	**Inspector Digital Signature**
Additional Inspector(s) Debra Churcher (670) Peter Hannaberg (721821) Christie Pollier (000749), attended this inspection during orientation.	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
January 30 – 31, February 2, 6-10, 13-16, 27-28, 2023.

The following intake(s) were inspected:

- Intake: #00016088 – Complaint – relating to improper/incompetent treatment of a resident.
- Intake: #00008696 – Complaint – relating to allegations of neglect.
- Intake: #00006961 – Critical Incident (CI) 3046-000088-22 – relating to allegations of neglect.
- Intake: #00008368 - CI 3046-000097-22 – relating to resident-to-resident responsive behaviours.
- Intake: #00013333 – CI 3046-000110-22 – relating to allegations of neglect.
- Intake: #00013558 – CI 3046-000113-22 – relating to allegations of neglect.
- Intake: #00013699 – CI 3046-000116-22 – relating to resident-to-resident responsive behaviours.
- Intake: #00013932 - CI 3046-000122-22 – relating to allegations of neglect.
- Intake: #00014181 – CI 3046-000124-22 LTCH – relating to allegations of neglect.
- Intake: #00014546 – CI 3046-000128-22 – relating to improper transfer.
- Intake: #00014688 – CI 3046-000130-22 – relating to resident-to-resident responsive behaviours.
- Intake: #00016336 – CI 3046-000136-22 – relating to improper/incompetent treatment of a resident
- Intake: #00016344 – CI 3046-000137-22 – relating to allegations of neglect.

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medications

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 140 (2)

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

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 131(2) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 140(2) of O. Reg. 246/22 under the FLTCA.

Non-compliance with s. 131(2) of O. Reg. 79/10 under the LTCHA

Rationale and Summary
A resident was prescribed a medication to be administered with specific instructions daily. Review of the residents Electronic Medication Administration Record (EMAR) indicated the medication was entered as a Pro Re Nata (PRN) frequency. The resident was noted to have met the requirements to receive the medication daily during an extended specific time frame. During a specific month, the medication was administered less than daily. The medication was not utilized at all during an extended specific time frame.

Non-compliance with s. 140 (2) of O. Reg. 246/22 under the FLTCA

Rationale and Summary
The resident was noted to have met the requirements to receive the drug daily during an extended specific time frame. The medication was not utilized during four of the months and medication was administered less than daily in another month.

The Director of Nursing Care (DNC) indicated the resident should have been given the medication daily after meeting the requirements and was not.

On another occasion it was documented in the progress notes and EMAR that the resident was given one tablet of a lesser strength pain medication instead of their regularly scheduled pain medication. During an interview with the DNC they indicated the expectation of registered staff was to administer medications as ordered.

Sources: Resident's clinical records and staff interview with the DNC.
[725]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1)

The licensee failed to immediately report an allegation of neglect of a resident to the Director.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 24 (1) of LTCHA, 2007.

Rationale and Summary
During record review of a resident's progress notes there was an entry, where the resident reported an allegation of neglect to the Registered Practical Nurse (RPN). The RPN reported the allegation to the Charge Nurse (CN) who advised to e-mail the Neighbourhood Coordinator (NC) and Assistant Director of Nursing Care (ADNC)'s.

The home's policy, stated in part, that all team members were required to report incidents or allegations of neglect and/or abuse immediately to any supervisor or any member of the leadership team and were

to have followed immediate reporting requirements to the Director.

The General Manager (GM) confirmed an e-mail was sent to the ADNC and a Critical Incident (CI) was not submitted to the Ministry of Long-Term Care (MLTC) and should have been.

Sources: Resident's progress notes, the home's policy and staff interview with GM.
[725]

WRITTEN NOTIFICATION: Plan of Care

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

The licensee failed to ensure that the care plan for a resident included the management of their pain specific to their diagnosis.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 26(3) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 29(3) of O. Reg. 246/22 under the FLTCA.

Non-compliance with s. 26(3) 10 of O. Reg. 79/10 under the LTCHA

Rationale and Summary
A resident was admitted to the home with a diagnosis that was known to cause a particular symptom. A progress note from the time of admission, indicated that the resident was indicating pain, at which time a treatment to manage the resident's pain was obtained. Review of the resident's care plan did not contain any information or direction to staff on the management of the resident's diagnosis and pain. The home's policy provided direction to staff on how and what to document relating to pain, including strategies to manage pain and update as required. Staff continued to obtain orders for the management of the resident's pain. During a specific timeframe, the resident continued to complain on and off of pain.

Non-compliance with s. 29(3) 10 of O. Reg. 246/22 under the FLTCA

Rationale and Summary

On a specific date, a registered staff documented a note for the upcoming physician rounds. The note from the registered staff had requested a stronger pain medication and that all other attempts to reduce the pain had been exhausted. The resident continued to experience pain during a specific timeframe. Review of the care plan for the resident indicated that a pain focus was not initiated until a specific date and did not include the original diagnosis as a cause.

During an interview with the ADNC they confirmed that the pain section of the care plan was not added until after the specific date, and that it did not reflect the resident's condition. The ADNC also indicated the expectation would have been to ensure that the care plan reflected the resident's condition.

Sources: Resident's records, the home's policy and staff interview with the ADNC.
[725]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (1) 3.

The licensee failed to 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 was dealt with as follows: The response provided to a person who made a complaint shall include, the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
A) Four separate e-mails were sent to the management team at the home relating to care concerns of a resident.

The inspector was unable to locate any responses that included the Ministry's toll-free telephone number for making complaints or contact information for the Patient Ombudsman.

During an interview with the GM they acknowledged that the complainant had not been provided with the contact information for the MLTC or the patient ombudsman.

Sources: Review of four complaint emails and four complaint responses and an interview with the GM.
[670]

B) A complaint was submitted to the home on a specific date. The home did not provide a response

letter to the complainant providing the contact information for the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsmen. The GM confirmed the information was not provided.

Sources: Complaint letter and staff interview with GM.
[725]

COMPLIANCE ORDER CO #001 Additional training — direct care staff

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 261 (1) 4.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the Licensee must;
A) Ensure all direct care staff complete the required annual education relating to the pain management program.
B) The education must include but is not limited to: the home's pain management program, identification of pain, how to accurately report pain from the resident, to PSW, to registered nursing staff to physician or Nurse Practitioner (NP).
C) Keep a record of the training, the training content, who completed the training and signatures of all staff that attended.

Grounds
The licensee failed to ensure that all direct care staff were educated relating to pain management for 2022.

Rationale and Summary
Review of the home's course completion record for the pain management course, showed that out of 268 staff listed, 77 had completed the required education. The GM indicated that the information was reviewed and none of the staff identified as not completing the education were noted to have been off in 2022.

The home's policy stated in part that, all staff will be annually required to complete mandatory education module on Pain Management through the learning platform in use.

The GM acknowledged that 191 staff members out of 268 did not complete the required education.

Sources: The home's education records and staff interview with the GM.
[725]

This order must be complied with by June 15, 2023

COMPLIANCE ORDER CO #002 Pain management

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 57 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the Licensee must;
A) Ensure all residents experiencing pain whose pain is not relieved by the intervention are reassessed by a member of the registered nursing staff.
B) The Director of Nursing Care or designate will conduct one audit, per unit, per month, for a total of eight audits a month, of a resident who has been administered a PRN medication.
C) The audit must include but are not limited to, assessing if the pain management program policy was followed, pain assessment completed, follow-up actions completed if required, review of the EMAR for PRN usage, if increased PRN analgesics used was follow up communications completed and documented with Physician or NP.
D) Keep a record of all audits and any deficiencies found, and any corrective actions taken.
E) Audits are to be conducted until the order is complied by an inspector from the MLTC.

Grounds
The licensee failed to ensure that a resident's pain was reassessed after the initial intervention did not relieve their pain.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 52(2) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 57(2) of O. Reg. 246/22 under the FLTCA.

Non-compliance with s. 52(2) of O. Reg. 79/10 under the LTCHA

Rationale and Summary
A resident was admitted to the LTCH with a specific diagnosis.

The resident complained of pain, from the specific diagnosis during the time of admission, at which time a PRN pain medication was given. The nurse documented on the EMAR that the PRN medication was ineffective. Review of the assessments indicated no pain assessment had been completed in follow-up on the same date. No additional doses of the PRN pain medication were given that day.

Non-compliance with s. 57(2) of O. Reg. 246/22 under the FLTCA

Rationale and Summary
The resident complained of pain on a specific date, at which time a registered staff completed a pain assessment, a PRN pain medication and treatment were administered. The registered staff documented on the EMAR and in the progress notes that the PRN medications were ineffective and that the resident remained in pain. Review of the assessments indicated no reassessment had been completed in follow-up. No additional doses of PRN pain medication or treatments were administered that day.

On a specific date, a registered staff documented a note for the upcoming physician rounds. The note from the registered staff had requested a stronger pain medication and that all other attempts to reduce the pain had been exhausted. Review of the assessments indicated no assessments had been completed during the time of the note. Review of the EMAR indicated that one PRN pain medication had been administered the previous day, and was documented as ineffective, and additional doses were not given when able on that date or the day after and had not been administered previously within a specific timeframe.

On the physician rounds communications sheet for a specific date, an unknown registered staff documented that a specific pain medication was ineffective in managing the residents' pain. Review of the assessments indicated a quarterly assessment completed a few weeks prior, which had shown that the resident's pain was managed with current interventions, no other assessments had been completed in that specific month relating to the resident's pain prior to or on the date of the physician communication. Progress notes from three consecutive dates indicated the resident was experiencing discomfort or pain. Review of the EMAR for the specific dates, indicated no PRN medication or treatments were administered during this time.

The Most Responsible Physician (MRP) indicated they received their information from the registered staff and did not review the EMAR for information of administered medications.

During an interview with the Pain Management Program lead ADNC, they indicated the expectation of staff would have been to complete a pain assessment prior to administering each PRN medication and to have completed an assessment post administration, if the initial interventions were ineffective. Also,

to utilize PRN medications to the ordered potential for optimal pain management.

Sources: The resident's medical records and staff interview with the ADNC.

[725]

This order must be complied with by May 15, 2023

COMPLIANCE ORDER CO #003 Plan of Care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 29 (3) 13.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must;
A) Update the Weight and Height Monitoring policy to include the Registered Dietitian's responsibility to update and consult the MRP when a resident is experiencing continued weight loss.

Grounds
The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following for a resident; Nutritional status including weight and any risks relating to nutritional care.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 26(3) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 29(3) of O. Reg. 246/22 under the FLTCA.

Non-compliance with s. 26(3) 13 of O. Reg. 79/10 under the LTCHA

Rationale and Summary
A resident's admission weight was documented as a specific amount in Kilograms (kg). Over a period of time the resident was noted to have a deficit of weight in comparison to admission weight. Referrals were made to the Registered Dietitian (RD) and interventions were initiated.

Non-compliance with s. 29(3) 13 of O. Reg. 246/22 under the FLTCA

Rationale and Summary
Over a specific course of time the resident continued to lose weight and remained in a weight deficit. Referrals were made to the RD and interventions were initiated.

Review of the home's policy did not include information on consulting additional disciplines when the interventions were ineffective at maintaining weight.

During an interview with the RD they acknowledged the interventions were not effective in maintaining the resident's weight and they had not consulted with the resident's MRP. The MRP confirmed they were not notified of concerns relating to weight loss.

Sources: Resident records, the home's policy and staff interview with the RD and MRP.

[725]

This order must be complied with by May 15, 2023

COMPLIANCE ORDER CO #004 Resident Records

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 274 (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must;
A) Educate all registered nursing and registered dietitian staff on the home's policy for documentation.
B) The education must include but is not limited to: accuracy of assessments, accuracy of communication to physicians and NPs, and documentation of resident and or POA communication and requests.
C) Keep a record of the training, the training content, who completed the training and signatures of all staff that attended.

Grounds
The licensee failed to ensure that a resident's records were kept up to date at all times relating to registered nursing and dietitian documentation.

Rationale and Summary
A) A resident had experienced a specific episode and referrals were sent to the RD on five separate

occasions. The RD had completed assessments and initiated interventions. A progress note was written on a specific date, by a NP and was included in the RD referral on one of the specific dates, inquiring if there was a specific assessment available.

The RD, indicated the NPs sometimes used referrals to the RD and this specific assessment type synonymously. The RD indicated they had conversations with the resident and their POA about the situation and indicated the resident declined the specific assessment. The RD confirmed that they did not document the conversations and did not consult the specific designation for an assessment. The home's policy stated in part: "document accurately and record each issue, describe all subjective data, including what you have seen, heard, smelled and felt with your hands".

B) A registered staff completed a Pain Review/History Assessment on a specific date. The assessment document indicated the Pain Review "is a tool to gather information about the resident: history of pain, the satisfaction of pain level, preferred treatments, frequency of PRN medication". The assessment indicated the resident's average pain score over the course of 30 days was zero and that no PRN medications were administered within the last 30 days. During the 30 day period, the resident had three different PRN analgesics administered eight times and pain assessments were completed on three separate occasions noting pain between 6-7 out of 10.

During an interview with the pain management program lead ADNC they indicated that this assessment did not accurately reflect the resident's pain. The home's policy title stated in part: "A good entry is thorough, with complete information about the resident, including all health concerns and/or nursing support actions and outcomes".

Sources: The resident's medical records, the home's policy and staff interview with the RD and ADNC.

[725]

This order must be complied with by May 15, 2023

COMPLIANCE ORDER CO #005 Duty to Protect

NC #009 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)]:
Specifically the Licensee must:
A) Update the Pain Management Program policy to include monitoring per shift for 72 hours that

includes a pain assessment for a resident who receives a change or a new analgesic order, and expresses a new and or worsening pain or discomfort.
B) All registered nursing staff must receive retraining on the home's Pain Management Program.
C) The retraining must include but is not limited to: when and how to complete a pain assessment, when and how to complete a reassessment of pain and what actions to take when the intervention is ineffective, review of the purpose of PRN medications, and communication with Physicians and/or NPs when requesting new or increased doses of analgesics.
D) Educate all Physicians and NPs on how to access and review the EMAR.
E) Keep a record of the training, the training content, who completed the training and signatures of all staff that attended.
F) Develop a policy and procedure on how to track the status of laboratory diagnostic tests and identify who is responsible.
G) Complete training on the newly developed policy and procedure relating to tracking the status of laboratory diagnostic tests with the identified responsible persons.

Grounds
The licensee failed to protect a resident from neglect by the 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.

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Non-compliance with s. 19(1) of the LTCHA

Rationale and Summary
A Resident was admitted to the home and had a known specific diagnosis. A progress note from the time of admission, indicated that the resident was indicating pain, at which time a treatment to manage the resident's comfort was obtained. A care plan was not created to identify pain, and goals to manage or interventions to reduce incidents of pain. The home's policy stated in part, "care plan for pain

including the cause, type and include support strategies related to assessed pain and symptom management in the plan of care within 24 hours of move in and update as necessary".

During a specific month, the resident was prescribed a medication to support comfort, with specific requirements to administer. The medication was not administered as prescribed during a specific timeframe; the DNC confirmed the medication was not administered as prescribed. The resident continued to complain of pain throughout the month, requiring PRN analgesics to have been administered 11 times. The home's policy and interview with the ADNC indicated a pain assessment was to have been completed on the administration of every PRN analgesic and was not. The resident's weight decreased from the initial admission weight; interventions were put in place to address the weight loss.

The resident continued to complain of pain throughout the next month. On a specific date, a regularly scheduled analgesic, was prescribed. The home's policy stated in part that, a pain assessment was to be completed when a "pain medication is changed". No assessment was found relating to initiation of a regular scheduled pain medication.

The same month, the resident reported an allegation of neglect to a registered staff. The registered staff reported the allegation to the CN who advised the RPN to e-mail the NC and ADNCs. The allegation was not reported to the Director. The resident's weight decreased again, the RD completed an assessment and indicated the resident stated their intake was down some due to pain. No additional supplements were ordered. The NP ordered an intervention to reduce a pain. In the same month, an order was obtained to manage the discomfort of the resident's specific diagnosis, no additional pain assessments were completed relating the identified pain.

Non-compliance with s. 24(1) of the FLTCA

Rationale and Summary
During a specific month, the resident was prescribed a medication to support comfort, with specific requirements to administer. The medication was not administered as prescribed for five additional months.

Over the course of an extended period of time, the resident continued to experience pain specific to their diagnosis. Review of the care plan for the resident indicated that a pain focus had not been initiated until a specific date, after a medical intervention.

During a specific month, a registered staff documented a note for the upcoming physician rounds. The

note from the registered staff indicated a request for stronger pain medication and that all other attempts to reduce pain had been exhausted. Review of the assessments indicated no assessments had been completed on the date the note was written. Review of the EMAR indicated that a PRN pain medication had been administered on the previous day, and was documented as ineffective, no additional doses were given when able on that date or the day after and had not been administered previously within a specific timeframe. The resident's weight decreased again.

During the next month, on the physician rounds communications sheet for a specific date, an unknown registered staff documented that a specific pain medication was ineffective in managing the resident's pain. Review of the assessments indicated a quarterly assessment completed a few weeks prior, which had shown that the resident's pain was managed with current interventions, no other assessments had been completed in that specific month relating to the resident's pain prior to or the date of the physician communication. Progress notes from three specific consecutive dates, indicated the resident was experiencing discomfort or pain. Review of the EMAR for the specific dates, indicated no PRN medication or treatments were administered during this time. The resident's weight decreased again. An assessment documented by the RD indicated the resident remained with the same nutritional interventions there were no changes to nutritional care plan required.

The next month, the resident was experiencing increased radiating pain. A diagnostic test was ordered and completed to rule out a specific diagnosis. Staff continued to complete monitoring for the resident for 20 days with no follow-up relating to the results of the diagnostic test.

During the same month the resident experienced an episode of specific pain. A registered staff assessed the resident but did not provide PRN medication as ordered for episodes of the specific pain.

During the same month, staff obtained an order for a time change for one of the resident's medications, at which time the medication was then documented as refused the majority of the time, without further assessment or documentation. The medication had not previously been refused. The registered staff who documented the majority of the refusals indicated the resident stated the administration made the resident uncomfortable. No follow up assessment or documentation was completed.

The resident was administered a PRN medication five times in a two week period, all documentation indicated interventions were effective in managing pain. After the two weeks the resident was ordered a stronger pain medication. The ADNC indicated the original pain medication wasn't working and they upgraded to a stronger pain medication. No assessment was found relating to the initiation of the stronger pain medication.

The resident continued to complain of pain. Later during that same month, a new order for the same

diagnostic test was obtained. The diagnostic test was completed and sent to the lab. Later the following month the resident began experiencing additional symptoms. A progress note indicated a portion of the results were pending. No further documentation noted relating to the diagnostic test were found. During that month the resident weight continued to decrease to a significant deficit. The RD acknowledged the interventions initiated to maintain the resident's weight were ineffective and had not consulted with the MRP relating to the resident's weight loss.

That month the resident received a new diagnosis and underwent a medical procedure.

The following month the resident requested a change in care status. During that month a registered staff completed a Pain Review/History Assessment on a specific date. The assessment document indicated the Pain Review "is a tool to gather information about the resident: history of pain, the satisfaction of pain level, preferred treatments, frequency of PRN medication". The assessment indicated the resident's average pain score over the course of 30 days was zero and that no PRN medications were administered within the last 30 days. During the 30-day period, the resident had three different PRN analgesics administered eight times and pain assessments were completed on three separate occasions noting pain between 6-7 out of 10.

DNC indicated it would have been the expectation of staff to have utilized the PRN medications and notify the physician if the pain was continuous. Pain program lead ADNC indicated it would have been the expectation of staff to have utilized the PRN medications to their fullest, completing pain assessments with administration and to have notified the physician as required. ADNC confirmed staff did not follow the policy relating to pain management and the plan of care was not specific to the resident's condition and needs.

Sources: Resident records, the home's policies and staff interviews with the DNC, ADNC's, RD and the registered staff.

[725]

This order must be complied with by May 15, 2023

COMPLIANCE ORDER CO #006 Maintenance Services

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 96 (2) (a)

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

Specifically the licensee must:
A) Conduct an inventory in the home of all lifts. The inventory is to include identifying information specific to each lift.
B) Develop a process to ensure that all lifts are reviewed daily, and the reviews are documented and include identifying information specific to each lift reviewed.
C) Conduct weekly audits of all lift reviews. Document any deficiencies identified, and any corrective action taken. Audits to be completed for 3 months or until the order is complied.
D) Develop a process to ensure the home is tracking all identified issues or concerns with any lifts, including the yearly preventative maintenance audit, and reconcile and track all repairs completed with the identified issues and concerns.

Grounds
The licensee failed to ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment, including mechanical lifts, were kept in good repair.

Rationale and Summary
The home submitted a Critical Incident System report (CIS) related to a specific incident. The Ministry of Long-Term Care received a complaint related to the same incident.

Review of a resident's clinical record showed that the resident experienced an incident, resulting in injuries requiring medical interventions.

During an interview with two staff they stated that they completed a pre-check of the required equipment and it passed the visual inspection. Both staff shared that during the incident they heard a loud sound and specific events followed. One of the staff attempted to intervene. Both staff stated they rechecked the equipment and found a defect and the equipment was removed from service.

This inspector was able to visualize the equipment and verified the staff noted defect.

Review of the equipment inspection checklist for a specific month showed that inspections were not completed during most of the month. The equipment inspection checklist did not include any serial number or identification of the equipment being audited.

During an interview with the NC they stated that the unit has several pieces of equipment and separate checklist should have been completed. The NC stated that the checklists were to be done every night and there should have been separate checklists completed. The NC acknowledged that the checklists do not indicate the specific equipment being audited. The NC acknowledged the equipment audit had not

been completed prior to the incident involving the resident.

During an interview with the Corporate Maintenance Supervisor (CMS) they stated that the home had a company come in yearly and inspect all lifts. A review of the annual audit was conducted and the CMS acknowledged that the audit had identified multiple equipment issues. The CMS stated that once the report was received a request would be sent to the vendor for repair if required.

The Inspector completed an audit of all equipment identified and all were noted to have been repaired with the exception of a piece on a specific equipment which was previously identified during the annual audit.

During interviews with both the CMS and GM neither could provide the Inspector with any tracking process in the home to ensure that the required repairs were completed.

Sources: CIS, Complaint, review of the resident's clinical record, review of the home's annual specific equipment audit, observation of specific equipment and, interviews with the staff.

[670]

This order must be complied with by May 15, 2023

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.