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

Original Public Report

Report Issue Date: June 12, 2024

Inspection Number: 2024-1475-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Sharon Farms & Enterprises Limited

Long Term Care Home and City: Earls Court Village, London

Lead Inspector	**Inspector Digital Signature**
Melanie Northey (563)	Melanie Northey Digitally signed by Melanie Northey Date: 2024.06.19 15:30:37 -04'00'

Additional Inspector(s)
Debbie Warpula (577)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
May 8, 9, 10, 13, 14, 15 and 16, 2024

The following Critical Incident (CI) intakes were inspected:

- Intake #00112484 [CI# 3047-000010-24] related to Prevention of Abuse

The following complaint intake(s) were inspected:

- Intake #00110832 Complaint related to Medication Management
- Intake #00111425 Complainant related to Skin and Wound Management, Medication Management and Therapy Services
- Intake #00113399 Complainant related to the Fall Prevention and Management

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- Intake #00113934 Complainant related to Prevention of Abuse, Pain Management, and Skin and Wound Management

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident;

The licensee failed to ensure that there was a written plan of care for the resident that set out the planned care for the administration of a specific treatment.

Rationale and Summary

A complaint was reported to the Ministry of Long-Term Care (MLTC) by a family member of the resident who had concerns related to the resident's administration of a specific treatment. A Physician Referral documented the resident could be

administered the treatment in the home.

A "MD" progress note documented the was administered the treatment, however there was no order for the administration as part of the electronic Medication Administration Record (eMAR). The Assistant Director of Care (ADOC) stated the treatment was administered by the physician and not the registered nursing staff, which was why the treatment may not have been documented as part of the eMAR. The resident's eMAR was reviewed and there was another order for a physician administered medication to be administered in the home.

The ADOC verified there was no order for the treatment that was to be administered at specific intervals to keep track of the schedule for this treatment administration and there should be an order in the eMAR.

The resident did not have a plan of care that included the administration of a specific treatment administered by physician. There was risk that the next treatment administration could be missed for administration.

Sources: resident clinical record, family interview, 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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care was provided

to the resident as specified in the plan for specific clinical monitoring.

Rationale and Summary
The resident was admitted to the home and an "Admission Order Set" was signed by the physician and initialed as checked by two registered nursing staff. The order set documented the clinical monitoring over a period of time. A progress note by the Registered Dietitian identified the resident had a diagnoses that supported the clinical monitoring.

The electronic Medication Administration Record (eMAR) had no admission order set documented for clinical monitoring. A Physician Referral progress note documented the resident was not clinically monitored since admission for their diagnosis.

The Assistant Director of Care (ADOC) and Registered Practical Nurse verified the admission order set was not implemented as part of the resident's plan of care. The resident was not clinically monitored for their diagnosis as planned. A baseline was not established putting the resident at potential risk for a negative health outcome.

Sources: resident clinical record and staff interviews.
[563]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer

necessary.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed and when an intervention was implemented as a safety strategy.

Rationale and Summary
The resident was observed multiple times and at no time was the resident observed in a specific activity. The Physiotherapist verified the care plan was not updated when the physiotherapy plan changed, and the resident was no longer participating in the activity with physiotherapy or the nursing staff. The Personal Support Worker (PSW) stated the resident did not participate in this activity with nursing staff and the resident used a mobility device for all locomotion.

Inspector #563 observed the resident in the morning, after breakfast, and this safety strategy was not in place. Inspector walked to the resident's room where the safety strategy was noted as available but not in use.

The Registered Practical Nurse (RPN) stated the safety strategy was implemented and verified they did not document an assessment through progress notes identifying the assessed need for the safety strategy and did not update the care plan to identify it as an intervention.

The resident's safety was at risk when the care plan directed staff to provide assistance with a specific activity the resident could no longer perform, and the resident required a specific strategy that was not added to the plan of care.

Sources: resident clinical record, observations and staff interviews.
[563]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

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:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that when the resident had a fall, a specific assessment was completed and the resident was monitored according to the physician's order and the policy.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee was required to ensure the Head Injury policy was complied with as a part of the Falls Prevention and Management Program.

Specifically, staff did not comply with a licensee policy which was part of the licensee's Falls Prevention and Management Program.

Rationale and Summary

A complaint was received by the Director concerning a resident who had a fall with injury. Review of the home's Falls Prevention and Management policy indicated that if a fall was not witnessed or the resident had hit their head, a specific assessment would be initiated in Point Click Care (PCC).

The physician's orders and physician progress notes indicated the resident was not monitored and assessed according to the assessment identified as part of the policy reviewed as part of the falls program.

The Assistant Director of Care (ADOC) and Interim DOC confirmed the assessment was not completed as ordered by the physician and staff had not followed the policy.

The home failed to complete the resident's assessment at the intervals described in the policy, putting the resident at risk of a negative health outcome.

Sources: resident clinical record, policies and staff interviews.
[577]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee has failed to ensure that behavioural triggers were identified for the resident who demonstrated responsive behaviours.

Rationale and Summary
A Critical Incident System (CIS) report was received by the Director which indicated the resident sustained an injury and was involved in an incident with another resident. The report documented a resident entered another resident's room and pushed them, resulting in an injury.

The home's policy "Behaviour Management Program, Resident to Resident Abuse"

documented that persons with actual or the potential to exhibit responsive behaviours were screened, assessed, reassessed, behavioural triggers were identified, and appropriate interventions were implemented for the safety of the person served and others. Behaviours would be identified and causes/triggers would be distinguished.

The resident who entered the other resident's room did not have information concerning their behavioural triggers as part of their care plan. The Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN) stated the resident has identified triggers and verified their triggers were not included in the resident's care plan.

The interim Director of Care (DOC) confirmed that staff were required to have identified behavioural triggers and they were to be implemented as part of the resident's care plan.

There was risk of harm to residents, the resident had displayed responsive behaviours that caused an injury to another resident, and triggers for their responsive behaviours were not identified in their care plan.

Sources: resident clinical record, policies and staff interviews.
[577]

COMPLIANCE ORDER CO #001 Required Programs

NC #006 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.

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. 53 (1) 4
Specifically, the licensee must:
a) Review and revise, as needed, the home's policy related to pain management and all associated tools. Ensure at least one member of the nursing management team, one member of the registered nursing staff and one member of the non-registered nursing staff participate in the review. A documented record of the review and/or revision, the date of the review, the changes made if any, and who participated must be maintained.
b) Review, update and fully implement the home's Admission Checklist and process to ensure it matches the requirements in the home's pain policy and procedures.
c) Develop and implement a communication process, if required, between the RAI Coordinator and the registered nursing staff when a resident has been identified with unresolved pain with a pain scale outcome of greater than zero upon completion of the RAI-MDS assessment, if required.
d) Ensure the home's policy related to pain management is complied with for a specific resident.
e) Ensure the home's policy related to pain management is complied with for a specific resident.

Grounds
A) The licensee has failed to ensure that when a resident experienced pain, a pain assessment was completed using the "TRC Comprehensive Pain Assessment".

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.

Ontario Regulation 246/22, s. 35 (2) states, each program must, in addition to meeting the requirements set out in section 34, (a) provide for screening protocols; and (b) provide for assessment and reassessment instruments.

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 policy, the licensee is required to ensure that the policy is complied with. Specifically, staff did not comply with the licensee's Pain Management policy which was part of the licensee's Pain Management Program.

Rationale and Summary
The Pain Management policy documented the utilization of the TRC-Comprehensive Pain Assessment for documentation for pain screening and for a more in-depth assessment.

The resident was admitted to the home and pain was identified for the resident. A TRC Comprehensive Pain Assessment was not completed within 24 hours of admission to establish a baseline and to assess for the presence of pain. The Admission and Quarterly Resident Assessment Instrument – Minimum Data Set (RAI-MDS) Assessments identified a Pain Outcome Score for unresolved pain. The Registered Nurse/Registered Practical Nurse (RN/RPN) did not initiate a TRC-

Comprehensive Pain Assessment when the Pain Outcome Score was greater than "0".

The Interim Director of Care (DOC) stated the RAI Coordinator was responsible for the completion of RAI-MDS assessments and if there was a pain scale of "1, 2 or 3" to indicate unresolved pain, the registered staff on the floor would likely be responsible for completing the TRC Comprehensive Pain Assessment.

The Interim Director of Care (DOC) verified that neither the Pain Assessment V.2 nor the TRC Comprehensive Pain Assessment was competed for the resident. The Resident Service Coordinator verified a TRC Comprehensive Pain Assessment or a Pain Assessment V.2 should have completed on admission for the resident.

The resident had a Monthly Pain Management Evaluation completed and the resident reported moderate to severe pain during care at a specific pain site. There were no previous progress notes that identified the specific pain site. The RN/RPN did not initiate a TRC-Comprehensive Pain Assessment. A progress note documented a family concern related to the resident's pain and the RN/RPN did not initiate a TRC-Comprehensive Pain Assessment when the resident verbalized new pain.

The resident reported new pain on a different date. Pain was documented as part of another evaluation where the resident was experiencing pain during a treatment and the RN/RPN did not initiate a TRC-Comprehensive Pain Assessment following the skin and wound care treatment.

The resident had another Monthly Pain Management Evaluation completed and the resident reported a new pain site and at times the intensity of their pain was severe. There were no previous progress notes that documented the new pain site

identified by the resident. The RN/RPN did not initiate a TRC-Comprehensive Pain Assessment when a new pain site was identified.

The resident had another Monthly Pain Management Evaluation and the resident reported sharp pain with movement. Resident also said at times the intensity of their pain was severe. The RN/RPN did not initiate a TRC-Comprehensive Pain Assessment when the pain was identified as worsening with an increased pain level since the last monthly pain evaluation.

The resident was observed by the Personal Support Worker to have increased pain and the resident's plan of care for specific activities of daily living (ADLs) had changed. There was evidence of pain during the provision of care and the RN/RPN did not initiate a TRC-Comprehensive Pain Assessment.

The Assistant Director of Care (ADOC) verified the home did not comply with the Pain Management policy in assessing the resident for the presence of pain using the TRC-Comprehensive Pain Assessment which was the clinically appropriate assessment instrument specifically designed for the assessment of pain for the reasons documented as part of the policy. The resident did not receive a comprehensive pain assessment since admission despite having experienced moderate to severe pain, experienced new pain, and pain during the provision of care. The resident was assessed on admission and quarterly through the RAI-MDS as experiencing unresolved pain without a comprehensive pain assessment.

Sources: Pain Management policy, resident clinical record review, resident observations, resident interviews, and staff interviews.
[563]

B) The licensee has failed to ensure that when the resident experienced pain, pain

assessments were completed using the "TRC Comprehensive Pain Assessment" and as needed (PRN) medication was administered according to the Pain Management policy.

Rationale and Summary

A Critical Incident System (CIS) report was received by the Director which indicated the resident sustained an injury. A complaint was received by the Director on alleging concerns with the resident's care.

The Pain Management policy documented the "TRC Comprehensive Pain Assessment" was used to provide standardized documentation for nursing to assess and manage residents' self-reporting and observed pain, regardless of cognitive status. The policy further indicated that for new or intermittent pain, staff were to administer as needed (prn) medication as indicated.

A physician progress note documented the resident had experienced severe pain, had been refusing to participate in a specific ADL due to pain which impacted the resident's participation in physiotherapy, and they were prescribed a PRN medication for pain.

A physiotherapy progress note documented the resident was experiencing pain and pain was the critical factor holding the resident back from progressing. Another therapy note documented the resident had refused therapy due to pain.

A review of the resident's pain scale on two dates indicated mild to severe pain at multiple times. The resident's electronic Medication Administration Records (eMAR) indicated the PRN medication was not administered when the resident had pain. A pain assessment was not completed when the resident's pain scales indicated a change in pain status, and the resident verbalized pain.

The Assistant Director of Care (ADOC) stated staff had not followed the home's Pain Management program when staff had not medicated the resident for pain and should have administered the PRN.

The interim DOC acknowledged the lack of pain assessments using the "TRC Comprehensive Pain Assessment"; they confirmed it was completed on re-admission, and should have been completed when there was a change in their current pain status; when the resident verbalized new pain; before and following skin and wound treatment; when there was evidence of pain during care, and when there was evidence that current pain management and treatment was not effective. Further, staff were to have administered PRN medications as indicated.

The resident was at risk when they were experiencing pain, refused to participate in a specific ADL due to pain which limited physiotherapy, their pain was not being reassessed and they were not administered a PRN medication.

Sources: Pain Management policy, resident clinical record review, resident observations, and staff interviews.
[577]

This order must be complied with by July 19, 2024

COMPLIANCE ORDER CO #002 Skin and Wound Care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

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. 55 (2) (b) (iv)

Specifically, the licensee must:

a) Ensure the registered nursing staff are accurately signing the eTAR only when a treatment protocol and/or when a weekly wound assessment is provided to a specific resident.

b) Ensure a Registered Practical Nurse (RPN) and three Registered Nurses receive training on the primary goals of the skin and wound management program, skin and wound assessment and documentation requirements. A documented record must be maintained of the training; including the date the training was provided, content covered as part of the training, and the names of the identified staff who participated.

c) Ensure the home is auditing the completion of initial and weekly skin assessments for a specific resident. A weekly audit shall be undertaken of the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. A documented record must be maintained of this audit, including the date the audit was completed, who completed the audit, the name of the resident the audit was completed for, any concerns identified, and the corrective action taken as a result of the audit. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds
The licensee failed to ensure that a resident exhibiting altered skin integrity was reassessed at least weekly if clinically indicated.

Rationale and Summary
A complaint was reported to the Ministry of Long-Term Care (MLTC) by a family member of a resident who had concerns related to the resident's skin integrity.

A Skin & Wound Evaluation note first identified the specific area of altered skin integrity for the resident. The next weekly assessment was dated a month later and the area had increased and an order for a treatment cream was to be applied to affected areas topically with a start date a month after the initial assessment.

The electronic Treatment Administration Record (eTAR) did not have a treatment or weekly wound assessment identified for the resident's this area of altered skin integrity. The eTAR, the next month, documented the area of altered skin integrity and the order for a weekly skin and wound assessment. Although nursing staff documented the weekly skin assessment as completed in the eTAR, there was no assessment completed for one week. The specific area of altered skin integrity was identified on admission; and treatment, monitoring and weekly assessments did not commence until a month later. The Assistant Director of Care (ADOC) verified there were no weekly wound assessments completed between for one month and for another week before the area was healed.

A Skin & Wound Evaluation note documented another area of altered skin integrity with no weekly skin and wound assessments completed for six weeks and the altered area of skin integrity increased in size.

A Skin & Wound Evaluation note documented another area of altered skin integrity where the nursing staff missed a weekly skin and wound assessment.

The Skin and Wound tab in Point Click Care (PCC) identified a new area of altered skin integrity. There was no weekly assessment completed for two weeks, and the eTAR was signed as "9=Other/See Nurse Notes" by a Registered Practical Nurse (RPN) with no progress note documented and no weekly skin assessment completed. The ADOC verified there was no weekly assessment completed for two weeks by the RPN even though it was signed in the eTAR as completed.

Another new area was assessed and there was no skin and wound assessment completed for two weeks. Again, the ADOC verified there was no weekly assessment completed for two weeks by the RPN even though it was signed in the eTAR as completed.

Another new area was assessed with no skin and wound assessment completed for one week, even though the eTAR was signed by a Registered Nurse (RN) as completed. The ADOC verified the weekly skin assessments were not completed.

Another new area was assessed with no weekly assessment completed for two weeks. The ADOC verified the eTAR was last signed as "9=Other/See Nurse Notes" by a RPN with a progress note identifying the area as resolved. The ADOC stated they reviewed the assessment picture, and the altered area of skin integrity was not healed.

A new area was assessed on admission and there were no weekly assessments completed for six weeks and no weekly assessment was completed at a different time for another two weeks. The eTAR was signed as completed by a RN on three different dates with no weekly skin assessment completed. The eTAR weekly

wound evaluation for this area was discontinued with no final skin assessment that it was healed or resolved. The ADOC verified there were missed weekly skin assessments and there was no final skin assessment that the area was healed or resolved. The ADOC verified if the eTAR was signed as complete, there should be a corresponding skin assessment competed.

The RPN verified they signed the eTAR on multiple dates for multiple areas of altered skin integrity but did not complete the skin assessments. The RPN stated they planned to complete the skin assessments the next day, but verified they did not return the next day and complete the assessments signed for. There was no follow up with oncoming registered nursing staff to complete the skin assessment and because the eTAR was already signed by the RPN, nothing would have flagged the nursing staff that the assessments were incomplete. The ADOC stated the eTAR should only be signed once a treatment or assessment has been completed.

Sources: resident clinical record, Skin and Wound policy, and staff interviews. [563]

This order must be complied with by July 19, 2024

COMPLIANCE ORDER CO #003 Pain Management

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

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. 57 (2)
Specifically, the licensee must:
a) Ensure that if a specific resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for the purpose of assessing pain.

b) Ensure that if a specific resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for the purpose of assessing pain.

Grounds

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

Rationale and Summary

A complaint was reported to the Ministry of Long-Term Care (MLTC) by a family member of the resident who had concerns related to the resident's pain management. The resident was observed multiple times and appeared comfortable, however the resident stated they had pain.

The interim Director of Care (DOC) verified the TRC-Comprehensive Pain Assessment was the clinically appropriate assessment instrument used by the home and was specifically designed to assess pain. The resident's pain was not relieved by the order prescribed for pain, and on multiple dates the resident's pain level was moderate to severe after the administration of the medication.

The “Weights and Vitals Summary - Pain Level” report identified a pain level which indicated moderate to severe pain over the course of six weeks.

A “Monthly Pain Management Evaluation” progress note documented the resident had moderate to severe pain during care at specific pain sites. Over the course for four months, the resident's pain level continued to be severe at times and was administered an “as needed” (PRN) medication for pain with no documented pain level prior to administration or a pain level after administration to indicate whether the medication was effective.

The resident developed pain at a specific pain site during care. The order prescribed for pain was administered and at times was ineffective in relieving the resident's pain and the pain level was severe at times. A TRC-Comprehensive Pain Assessment was never completed. The resident had not been assessed for pain since admission and the level of pain was not documented before or after the administration of a medication as needed to determine effectiveness in relieving pain. The resident continued a medication management plan that included a prescribed order for pain and a PRN medication and continued to have pain levels of moderate to severe during that time.

Sources: resident clinical record, resident observations and interviews, and staff interviews.
[563]

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

Rationale and Summary
A Critical Incident System (CIS) report was received by the Director which indicated the resident sustained an injury. A complaint was received by the Director alleging concerns with the resident's care.

The resident's medical records documented a pain assessment completed on re-admission which indicated the resident had no pain.

A review of the resident's pain scale on two dates indicated mild to severe pain at multiple times. A physician progress note documented the resident had experienced severe pain and had been refusing to participate in a specific ADL due to pain which impacted the resident's participation in physiotherapy, and they were prescribed a PRN medication for pain.

A physiotherapy progress note documented the resident was experiencing pain and pain was the critical factor holding the resident back from progressing. Another therapy note documented the resident had refused therapy due to pain.

The interim Director of Care (DOC) acknowledged the pain assessment was completed on re-admission and confirmed there were a lack of pain assessments on dates where the resident's pain remained unresolved.

The resident was at risk when they were experiencing pain, their pain was not being reassessed and they were not administered a PRN medication to resolve pain.

Sources: resident clinical record review, resident observations, and staff interviews. [577]

This order must be complied with by July 19, 2024

COMPLIANCE ORDER CO #004 Administration of Drugs

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

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 a specific resident has an order documented as part of the electronic Medication Administration Record that provides clear direction for the administration of the medication, and the medication is administered in accordance with the directions for use specified by the prescriber, if required.
b) Ensure a specific resident is made aware of the results of the procedure, if required.
c) Ensure a specific resident's plan of care for pain management is reviewed with the resident and the resident's substitute decision-maker, if any. The review is to include all pharmacological and non-pharmacological strategies to manage pain.
d) Ensure a specific resident is administered pain medications in accordance with the directions for use specified by the prescriber.
e) Ensure a specific resident's plan of care for pain management is reviewed with the resident and the resident's substitute decision-maker, if any. The review is to include all pharmacological and non-pharmacological strategies to manage pain.
f) Ensure a specific resident is administered pain medications in accordance with the directions for use specified by the prescriber.

Grounds

A) The licensee failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

The resident reported a complaint related to the administration of medications to the Ministry of Long-Term Care. The resident stated they had a new concern related to a procedure booked where the nurse did not provide the specific physician's order and it had to be rebooked. The resident stated the physician's order was provided again on a different date for the rebooking of the procedure.

The Assistant Director of Care (ADOC) verified the order was vague, but that there was likely an instruction sheet that accompanied the order for nursing staff to use as a guide for the administration times. There was no instruction sheet or other documentation as part of the resident's clinical record describing the procedure for the administration of the physician's order.

A physician's note documented the nursing staff were to provide the specific order as prescribed as it was not given as prescribed according to the resident. The physician's "Assessment/Plan" documented, the physician would speak to nursing staff to assure the order was administered correctly. The physician acknowledged concerns with the medication administration.

The interim Director of Care (DOC) reviewed the order with the ADOC and Inspector #563 and verified there was no documentation that the order was administered as ordered prior to the procedure time.

It was unclear if the resident received the order as prescribed, the order was vague and there was one administration time and did not account for the entirety of the

administration over a specific time frame. The resident had to complete the order administration on two separate dates and the home failed to administer the prescription as ordered on both dates.

Sources: resident clinical record, resident interview and staff interviews.
[563]

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

Rationale and Summary
A complaint was reported to the Ministry of Long-Term Care (MLTC) by a family member of a resident who had concerns related to the resident's pain management. The resident was observed multiple times and appeared comfortable, however the resident stated they had pain. The Personal Support Worker (PSW) stated the resident did not participate in the specific activities with nursing staff due to pain.

The resident had an order for a pain mediation and on multiple dates the resident's pain level was moderate to severe. The resident also had an “as needed” (PRN) order available for administration for pain.

A “Monthly Pain Management Evaluation” progress note documented the resident had a level of pain that was severe. The Assistant Director of Care (ADOC) explained that nurses document the resident's current perception of pain at the time of the monthly evaluation and the resident reported a severe pain level and there was no PRN pain medication provided at that time.

The electronic Medication Administration Record (eMAR) documented to monitor pain each shift every shift if the pain level exceeded “2” or greater. The resident was

documented with a pain level of greater than "2" nine times with no PRN pain medication provided. Th ADOC verified the resident should have been administered a pain medication as needed for the presence of pain with a pain level greater than "2".

The eMAR also documented that registered nursing staff were to complete vitals monitoring at specific times on specific dates and the resident had moderate pain with no PRN pain medication administered. The resident was not provided pain management as prescribed PRN when pain levels indicated pain.

Sources: resident clinical record, resident observations and interviews, and staff interviews.
[563]

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

Rationale and Summary
A Critical Incident System (CIS) report was received by the Director which indicated a resident sustained an injury. A complaint was received by the Director alleging concerns with the resident's care.

The home's policy, PRN Administration and Documentation, documented that if a resident was experiencing symptoms and has an "as required" (PRN) medication on hand, registered staff may administer as needed. Staff were to administer the medication to the resident and observe the effect. The home's Pain Management policy documented that for new or intermittent pain, staff were to administer PRN medication as indicated.

The physician's orders indicated a PRN medication as needed. A review of the resident's pain scale on two dates indicated mild to severe pain at multiple times.

The electronic Medication Administration Record (eMAR) documented the PRN pain medication was not given when the resident had pain. A physician progress documented the resident was experiencing severe pain and was prescribed a PRN pain medication.

The Assistant Director of Care (ADOC) advised that registered staff should have administered the PRN as ordered when the resident was in pain. The ADOC advised staff had failed to administer PRN pain medication as ordered and the resident was at risk of experiencing unresolved pain.

Sources: policies, resident clinical record review, resident observations, and staff interviews. [577]

This order must be complied with by July 19, 2024

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

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.