Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton Service Area Office
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Original Public Report

Report Issue Date September 14, 2022
Inspection Number 2022_1540_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Regional Municipality of Niagara

Long-Term Care Home and City
The Meadows of Dorchester, Niagara Falls

Lead Inspector
Phyllis Hiltz-Bontje #129

Additional Inspector(s)
Aileen Graba #682

Choose an item.

Phyllis Hiltz-bontje
Digitally signed by Phyllis Hiltz-bontje
Date: 2022.10.24 11:08:06 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21 and 22, 2022.

The following intake(s) were inspected:

- #010117-22 (Complaint) related to falls prevention and pain management.
- #010118-22 (CIS) M515-000011-22 related to unexpected death.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Pain Management
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION [REPORTING CERTAIN MATTERS TO THE DIRECTOR]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 28 (1) 1.

Non-compliance with: FLTCA, 2021 *s.28 (1) 1.*

The licensee has failed to ensure that the Director was immediately notified when the Administrator and the Director of Resident Care (DRC) had reasonable grounds to suspect a resident may have sustained injuries during an interaction with staff.

Rationale and Summary

An incident occurred when a staff member attempted to redirect a resident. During this incident the resident fell which resulted in a change in the resident's health status.

The Director of Resident Care (DRC) had reasonable grounds to suspect the injuries sustained by the resident occurred during the above noted incident when they confirmed this suspicion to the inspector at the time of the inspection.

The Administrator said they believed the injuries sustained by the resident could have occurred during the interaction with the staff member.

Failure to report to the Director in accordance with the legislative requirement posed no risk to the resident.

Sources: resident Incident Note and RNAO: Post Fall Assessment, e-mails from a RPN and a RN to DRC, X-Ray report and interviews with the resident's family member, the DRC, and the Administrator**.**

#129

WRITTEN NOTIFICATION [REPORTING CRITICAL INCIDENTS]

NC#02 Written Notification pursuant to O. Reg. 246/22, s 115(1)

Non-compliance with: O. Reg. 246/22 s. 115 (1) 1.

The licensee has failed to ensure the Director was immediately informed of the unexpected death of a resident.

Rationale and Summary

A resident's clinical record indicated they were found to be without vital signs. The resident's physician indicated the resident's death was unexpected and contacted the coroner's office.

The Administrator confirmed the unexpected death of the resident was not immediately reported to the Director as was required.

Failure to report to the Director in accordance with the legislative requirement posed no risk to the resident.

Sources: The resident's progress notes, Institutional Patient Death Record and interviews with the resident's Physician and the Administrator.

#129

WRITTEN NOTIFICATION [FALLS PREVENTION AND MANAGEMENT]

NC#03 Written Notification pursuant to O. Reg. 246/22, s. 54 (2)

Non-compliance with: O. Reg. 246/22 *s. 54 (2)*

The licensee has failed to ensure that a post-fall assessment was completed using a clinically appropriate assessment instrument that was specifically designed for falls when a resident fell.

Rationale and Summary

A resident's clinical record indicated that a Registered Nurse (RN) was called to assess the resident when the resident fell.

The RN documented their assessment of the resident on an electronic "Incident Form" which was part of the home's Risk Management System. The "Incident Form" was a generic tool that could be used for any type of incident and was not specifically designed for the assessment of a resident when they had fallen.

The DRC confirmed that following the fall the resident was not assessed using a clinically appropriate assessment instrument.

There was an increased risk that the resident may not have been thoroughly assessed at the time of the incident when staff did not use a clinically appropriate assessment tool specifically designed to assess a resident who had fallen.

Sources: a resident's progress notes, the licensee's "Falls Prevent Program" policy and an interview with the DRC.

#129

WRITTEN NOTIFICATION [DEALING WITH COMPLAINTS]

NC#04 Written Notification pursuant to O. Reg. 246/22, s. 108 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The licensee has failed to ensure a complaint made to Administrator and the DRC about the care of a resident was investigated and a response provided to the complainant.

Rationale and Summary

A family member confirmed they attended a meeting with the Administrator and the DRC because they wanted answers about what happened to the resident and to talk about the concerns, they had related to the care of the resident following an incident which resulted in a change in the resident's health status.

The family member indicated to the inspector they had requested a copy of the investigation the home completed but were not provided with any information.

In response to a request for the home to provide documentation that they had investigated the incident, the Administrator provided a basic summary sheet of events related to the care of the resident and written statements by two PSWs, a RPN and a RN.

The DRC and Administrator were aware the resident's family had concerns. Not all staff involved in the incident were interviewed as part of the investigation. A response was not provided to the family.

The risk that similar care incidents may occur, increased when the home did not complete a thorough investigation into the concerns related to the care of the resident.

Sources: DRC's handwritten notes of a meeting with the resident's family, interviews with a family member, the DRC, and the Administrator.

#129

WRITTEN NOTIFICATION [DEALING WITH COMPLAINTS]

NC#05 Written Notification pursuant to O. Reg. 246/22, s. 108 (2)

Non-compliance with: O. Reg. 246/22, s. 108 (2)

The licensee has failed to ensure a documented record of a complaint made by the family of a resident related to their care was kept in the home.

Rationale and Summary

A resident's family member lodged complaints and concerns related to a fall incident and the care of the resident.

The Administrator confirmed they had not initiated the complaint process related to those complaints and concerns, did not initiate a complaint log and they were unable to provide documentation of what actions were taken in response to the complaints/concerns raised by the resident's family.

The home's failure to maintain a record of complaints posed no risk to the resident.

Sources: DRC's handwritten notes and an interview with the Administrator**.**

#129

WRITTEN NOTIFICATION [POLICIES, ETC., TO BE FOLLOWED AND RECORDS]

NC#06 Written Notification pursuant to O. Reg. 246/22, s. 11 (1) (b)

Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)

The licensee has failed to ensure staff complied with the licensee's written procedure related to the complaint process when a resident's family raised concerns about the care of the resident.

Rationale and Summary

FLTCA 2021, s. 26 (1) (a) directs that every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complainants to the licensee and how the licensee deals with complaints.

Staff failed to comply with directions included in the licensee's "Complaint Process" procedure, identified as AD05-001, last revised on February 29, 2022, and included in the Administration Manual when the following occurred:

a) The "Complaint Process" procedure directed that all verbal and written complaints are to be investigated within 10 business days of receipt of a complaint.

   The Administrator acknowledged that a resident's family members raised concerns about the care of the resident, concerns about how the resident could have sustained injuries and verified that those complaints and concerns had not been investigated.

The DRC confirmed they had not directed anyone to initiate an investigation into the concerns raised by the resident's family.

b) The "Complaint Process" procedure directed that a specific complaint documented record was to be kept in the home that included: the nature of the complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for action to be taken and any follow-up action required, the final resolution if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

The Administrator acknowledged that the home had not initiated the homes complaint process when a resident's family members raised care concerns and there was not a documented record of the complaint in accordance with the specific requirements in the licensee's policy.

The failure of staff to comply with the licensee's "Complaint Process" procedure did not pose a risk to the resident.

Sources: licensee's "Complaint Process" procedure and interviews with the DRC and the Administrator.

#129

WRITTEN NOTIFICATION [REQUIRED PROGRAMS]

NC#07 Written Notification pursuant to O. Reg. 246/22, s. 53 (1) 1.

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

The licensee has failed to ensure that the Falls Prevention and Management Program was fully implemented when staff did not comply with program directions and procedures included in the program when a resident fell.

Rationale and Summary

O. Reg. 246/22 s. 34(1) 1, directed that for each of the required programs identified under regulation 53 (1) there must be relevant policies, procedures, and protocols.

O. Reg. 246/22 s. 53 (1) 1. directed that the licensee is to develop and implement a falls prevention and management program to reduce the incidents of falls and the risk of injury.

O. Reg. 246/22 s. 11 (1)(b) directed that where the act or the regulation requires the licensee to have, institute or otherwise put in place any program, policy, protocol or procedure, the program policy, protocol, or procedure must be complied with.

a) Staff did not comply with procedures in the licensee's Falls Prevention Program, identified as MP00-002, last revised on May 2, 2022, and included in the Resident Care and Services Manual. This program directed that it was the responsibility of the registered staff to "complete a thorough assessment of the resident following a fall, complete the RNAO Post Fall Assessment Order Set and documentation as required".

A resident fell and during the incident they experienced injuries and a change in their health status.

The DRC confirmed that registered staff had not complied with the procedure when they did not complete RNAO Post Fall Assessment Order Set document at the time of the fall.

b) Staff did not comply with the 'Post Fall Assessment" procedure identified as PCS04-11, last revised on March 22, 2022, which directed that Registered staff may initiate the Glasgow Coma Scale if indicated.

In accordance with the licensee's "Head Injury Policy", identified as PCS04-003, last revised on November 1, 2021, completion of the Glasgow Coma Scale was indicated when the policy directed, "all residents who have potentially suffered a head injury, or a head injury not related to a fall will be assessed by registered nursing staff using the Glasgow Coma Scale to determine the resident's neurological level".

A resident fell and clinical records of the incident indicated the resident's neurological function changed, which may have indicated a potential head injury.

A RN and the resident's clinical record confirmed that staff had not initiated the use of the Glasgow Coma Scale tool to assess the resident's neurological function in accordance with the licensee's procedures when symptoms demonstrated by the resident could indicated the resident may have sustained a head injury.

The risk that the resident may have sustained injuries that went unnoticed and potentially untreated increased when registered staff did not follow the licensee's program and procedure directions for assessing the resident when they fell and when their neurological function changed.

Sources: a resident's progress notes and electronic assessment tab, licensee "Falls Prevention and Management Program", "Post Fall Assessment Procedure" and "Head Injury Policy", as well as interviews with a RN and the DRC.

#129

WRITTEN NOTIFICATION [REQUIRED PROGRAMS]

NC#08 Written Notification pursuant to O. Reg 246/22, s. 53 (1) 4.

Non-compliance with: O. Reg. 246/22 s. 53 (1) 4.

The licensee has failed to ensure the required Pain Management Program was fully implemented when staff failed comply with the policy related to the assessment and monitoring of a resident when they experienced pain.

Rationale and Summary

O. Reg. 246/22 s. 34 (1) 1. directed, for each of the required programs under section 53 of this regulation there must be a written description of the program that included relevant policies and procedures.

O. reg. 246/22 s. 53 (1) 4. directed, the licensee is to develop and implement a pain management program to identify pain in residents and manage pain.

O. Reg. 246/22 s. 11(b) directed that where the act or this Regulation requires the licensee to have, institute or otherwise put in place any policy or procedure, the licensee is required to ensure the policy or procedure is complied with.

The licensee's policy "Pain Assessment and Management Program", identified as MP00-004 and last revised on April 11, 2022, provided the following directions to staff:

i. "When a resident verbalized pain, or when there is evidence of pain during the provision of care, the Registered staff must be notified, and a pain assessment will be completed."

Registered staff did not comply with this direction when four PSWs, who provided care to a resident confirmed they reported to the Registered Practical Nurses (RPNs) who worked at the time, that the resident demonstrated they had pain when care was provided. Following a review of the resident's clinical record a RN confirmed no pain assessments were documented in resident's clinical record.

ii. "A pre/post-intervention pain assessment will be done when pain is detected for all residents who receive routine or as needed pain management, to ensure the resident's pain is assessed and documented before the intervention and will reassess the effectiveness of the intervention 30 minutes to one hour after the medication was administered."

A RPN did not comply with this direction when they administered a medication for pain management to a resident. The clinical record and a RN confirmed that the RPN had not returned to reassess the effectiveness of the medication for seven hours after it was administered.

iii. "All residents will have their pain assessed when there are significant changes using the Pain Assessment in Point Click Care (PCC). Registered staff will assess

a resident's pain using the PAINAD assessment for residents who are unable to self-report pain."

Registered staff did not comply with this direction when a resident experienced changes in their health status which included pain associated with two injuries they sustained during a fall. A RN confirmed that Pain Assessments in PCC had not been completed when the resident demonstrated they experienced pain.

iv. "The effectiveness of the pain interventions will be documented in PCC using the Pain Progress Note."

Registered staff did not comply with this direction when a resident was administered both narcotic and non-narcotic medication for pain. The clinical record and a RN confirmed that no Pain Progress notes had been completed in PCC for this resident.

v. "If a resident complains of pain and/or if non-verbal cues of pain are present PSWs are to document on a Point Of Care (POC) task under "Pro re nata" (PRN).

PSW staff did not comply with this direction when four PSWs confirmed when they provided care to a resident, the resident demonstrated they had pain and they did not document this in a POC task.

The "Clinical Documentation and Information" staff lead reviewed the POC tasks identified in the resident's clinical record and confirmed PSWs had not documentation that the resident demonstrated pain, as required.

The failure of staff to comply with the licensee's policies and procedures related to pain management resulted in incomplete records of the assessment and care provided to a resident and increased the risk that the resident would not receive appropriate monitoring and treatment to manage the pain they experienced.

Sources: a resident's clinical record and Medication Administration Record, the licensee's Pain Management Program policy and interviews with PSWs, a RPN and RNs.

#129

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#09 Written Notification pursuant to O. Reg. 246/22, s. 102 (15) 2.

Non-compliance with: O. Reg. 246/22, 102 (15) 2

The licensee has failed to ensure that the infection prevention and control lead worked regularly in that position on site in a home, with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

Rationale and Summary

The homes infection prevention and Control (IPAC) leads job description identified the standard hours of work as 35 hours per week.

The Associate Director of Resident Care (ADRC) confirmed that they were designated as the IPAC lead for the month of May 2022. The ADRC acknowledged that IPAC was not their primary focus and that the time spent on IPAC was less than 26.25 hours, approximately 18 - 22 hours per week. The DRC stated that they assumed the role of IPAC lead June 6, 2022. The DRC also confirmed that they did not primarily focus on IPAC and worked approximately 10 hours per week coordinating the IPAC program. The Administrator confirmed the home had 121 beds.

The residents were placed at risk for the transmission of infection when the two staff designated as IPAC leads did not perform that function and comply with the specific IPAC provisions of the Act and Regulations.

Sources: Niagara Region Job Description IPAC Program Manager Community Services (ND), interviews with ARDC, DRC, Administrator

#682

WRITTEN NOTIFICATION [AIR TEMPERATURES]

NC#10 Written Notification pursuant to O. Reg. 246/22, s. 24 (3)

Non-compliance with: O. Reg. 246/22 *s. 24 (3)*

The licensee has failed to ensure that the temperature was measured and documented in writing at a minimum, in at least two residents' bedrooms in different parts of the home, one resident common area and designated cooling area of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary

The home's temperature logs were reviewed from June 1 to July 10, 2022, and temperature measurements of either resident bedrooms, resident common areas

and/or designated cooling areas were not documented on 23 occasions over 18 days within the review period. The Environmental Services Manager (ESM) and Program Manager acknowledged that the temperature log documentation did not include all the temperature measurements as required.

By not recording temperatures in different parts of the home at required frequencies, there was risk of unacceptable temperatures that may not have been identified.

Sources: Temperature logs June 1- July 10, 2022, Interview with the ESM, Program Manager, and other staff.

#682

COMPLIANCE ORDER [CO#01] [PLAN OF CARE]

NC#11 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (b) prepare, submit and implement a written plan for achieving compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 29 (3) 10

Specifically, the licensee shall prepare, submit, and implement a plan to ensure when a resident experiences new or worsening pain or when a resident experiences a change in their level of consciousness, their plan of care is based on an assessment by a member of the registered nursing staff.

The plan must include but is not limited to:

1. A process for the review of the expectations related to the assessment of a resident when they experience new or worsening pain or a change in their level of consciousness by all registered staff who regularly work on the Trillium home area. A record of this review is to be maintained in the home.

2. A method that will ensure the Director of Resident Care is notified when a resident on the Trillium home area experiences new or worsening pain or a change in their level of consciousness. A record of the notifications, that can be viewed by an inspector is to be maintained in the home.

3. A process for members of the nursing leadership team to audit assessments completed when a notification is received that a resident has demonstrated new or worsening pain and when a resident experiences a change in their level of consciousness. The completed audits are to be maintained in the home.

4. The auding process is to continue for three weeks after the compliance due date.

Please submit the written plan for achieving compliance for inspection #2022_1540_0001 to Phyllis Hiltz-Bontje, LTC Homes Inspector, MLTC, by email to HamiltonSAO.moh@ontario.ca by September 27, 2022.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.

The licensee has failed to ensure a resident's plan of care was based on an assessment of pain and a special need related to a change in their level of consciousness following a fall.

Rational and Summary

A resident experienced a fall incident which resulted in the resident experiencing pain from injuries and a change in their level of consciousness.

A. The licensee failed to ensure the resident's plan of care was based on an interdisciplinary assessment of pain.

The resident's plan of care was not based on an interdisciplinary assessment when registered nursing staff did not document pain assessments following an incident that resulted in the resident experienced pain following a fall.

Clinical progress notes and the Physiotherapist indicated they were called to assess the resident the morning of the incident. They confirmed they assessed the resident and suggested X-Rays be taken based on pain the resident demonstrated during the assessment and indicated this information was shared with registered staff.

The clinical record and the Physician indicated they saw the resident the morning of the incident, ordered X-Rays of several areas and ordered a narcotic pain medication to manage the pain the resident experienced.

Four PSWs who provided care to the resident, confirmed they observed the resident to be in pain when care was provided and verbally communicated this to registered staff.

The clinical record and the resident's family member confirmed they expressed concern about the pain the resident experienced, and concern related to the lack of pain management to the registered staff.

The Medication Administration Record (MAR) indicated the Physician increased the amount of the narcotic medication over the following days to better manage pain the resident experienced.

A RN explained registered staff were to document pain assessments in accordance with the policy on a specific "Pain Assessment Note" found in the progress note tab, a specific Pain Assessment, found in the assessment tab or a Non-triggered Pain Resident Assessment Protocol found in the Resident Assessment Instrument-Minimum Data Set tab in the electronic record.

Following a review of the resident's clinical record, a RN confirmed there was no indication in the resident's clinical record that registered staff completed pain assessments for the resident at any time following the incident.

The failure of staff to complete regular pain assessments for the resident may have resulted in the resident's pain not being managed, and they continued to experience pain.

B. The licensee has failed to ensure that a resident's plan of care was based on an interdisciplinary assessment of a special need when they demonstrated an altered level of consciousness following a fall.

A resident's clinical notes indicated the resident experienced a change in their level of consciousness that continued to fluctuate over a period of days.

The licensee's policy "Post Fall Assessment" and "Head Injury Routine" policies indicated that registered staff may initiate the Glasgow Coma Scale at any time if indicated and the Glasgow Coma Scale assessment was to be completed post fall with head injury or suspected head injury from other cause not related to a fall.

Staff who provided care to the resident over a three-day period indicated and documented, the resident had demonstrated behaviours that would indicate a change in the resident's neurological function.

A family member indicated they knew something was not right with the resident because they were not responding as usual.

A RN reviewed the resident's clinical record and confirmed the resident's plan of care had not been based on an assessment of the resident's level of consciousness when Glasgow Coma Scale assessments had not been completed.

The failure of staff to assess the resident's level of consciousness when it was identified their level had changed increased the risk that a possible head injury sustained by the resident would go unrecognized and any potential treatment would not be provide.

Sources: a resident's clinical progress notes, Medication Administration Record, licensee "Pain Assessment and Management" policy, "Post Fall Assessment" policy and "Head Injury Routine" policy, as well as interviews with a family member, PSWs, a RPN, RNs, Physiotherapist, and the Physician.

This order must be complied with by November 30, 2022

COMPLIANCE ORDER [CO#02] [WHEN REASSESSMENT, REVISION IS REQUIRED]

NC#12 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6 (10) (b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA 2021, s. 6 (10) (b)

Specifically, the licensee must:

Ensure when a resident's care needs change the plan of care is reviewed and revised, by completing an audit following all resident falls. The audit is to include interviews with Personal Support Workers and registered staff related to the current care needs of the resident and a review of the plan of care to ensure the directions for care are consistent with the needs of the resident. Auditing is to continue for three weeks post compliance due date. A copy of the audits must be maintained in the home.

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Grounds

Non-compliance with: FLTCA 2021, s. 6 (10) (b)

The licensee has failed to ensure a resident's plan of care was reviewed and revised when their care needs changed after they experienced a fall.

Rational and Summary

A resident experienced a fall, which resulted in the resident experiencing a change in their care needs over eight major care areas.

A review of the care plan confirmed the plan of care had not been reviewed and revised with current care directions for the eight major care areas when the resident experienced a change in their care needs.

A family member confirmed they visited the resident on the day of the fall, and they noted the resident's care needs had changed from the previous day.

A PSW provided care to the resident during the day after the fall and confirmed the resident had significant changes related to their care needs and was not aware that any changes had been made to the resident's care plan.

A PSW confirmed they provided care to the resident during the evening after the fall and indicated the resident's care need had changed. The PSW confirmed they were not provided with care directions related to the changes they noted in the resident's abilities.

Following a review of the care plan the DRC confirmed that the care plan had not been reviewed and revised following the fall and did not reflect the current care needs of the resident.

The failure of registered staff to review and revise the resident's plan of care resulted in staff not having clear direction related to the type and level of care the resident required, which placed the resident at risk of not receiving the care they required.

Sources: the resident's progress notes and care plan, X-Ray report, and interviews with the resident's family member, PSWs and the DRC.

This order must be complied with by November 30, 2022

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COMPLIANCE ORDER [CO#3] [RIGHT TO QUALITY CARE AND SELF-DETERMINATION]

NC#13 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021, s. 3 (1) 16

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA 2021, s. 3 (1) 16

Specifically, the licensee must:

1. Engage all staff who work regularly on the Trillium home area in discussions about the meaning of a resident's right to receive proper care that is consistent with their needs and how each staff member can ensure this right is being afforded to the resident's they provide care to.
   Documentation of the discussions and practice ideas are to be documented and maintained in the home.

2. Provide training to all nursing staff who regularly work on the Trillium home area related to the impact pain has on the quality of life of the residents.
   Training records that include the content of the training and names of the participants are to be maintained in the home.

3. Develop and implement a survey to determine the barriers staff face in reviewing and following the licensee's policies and from the survey results, develop and implement a plan to address the barriers identified.

   Documentation of the survey results and the plan for correction are to be kept in the home.

Grounds

Non-compliance with: FLTCA 2021, s. 3 (1) 16

The licensee has failed to ensure a resident's right to receive proper care based on their needs, was fully respected and promoted following an incident that resulted in the resident

experiencing a significant change in their health status that included injuries and a change in their level of consciousness.

Rational and Summary

A. Staff failed to ensure proper care and services were provided to a resident when they experienced a significant change in their care needs.

During the course of this inspection, it was identified that a resident's care needs changed following an incident that resulted in a fall, a change in their level of consciousness, pain from injuries received and a loss of functional abilities.

Prior to the incident staff who cared for the resident and the resident's Physician indicated the resident was mostly independent with activities of daily living.

Family members also indicated the resident would interact with them during their visits and would engage in activities during family visits.

Following the incident, the resident was unable to complete any independent activities.

1. A resident's right to proper care was not respected when registered staff did not complete assessments of the changes in care needs demonstrated by the resident following the incident and did not update the resident's care plan to ensure care staff had clear direction related to the type and amount of care the resident required.

The lack of specific care directions to meet the resident's needs resulted in inconsistent care when each staff member made decisions at the time related to the type and level of care provided.

A family member indicated when they visited the resident the day following the incident, the resident indicated and demonstrated they experienced pain.

PSWs were not aware of the possible injuries the resident may have sustained or the methods they were to use when providing care that did not cause the resident additional pain.

2. A resident's right to proper care consistent with their needs was not respected in relation to the management of pain they experienced.

i. Four PSWs indicated they had provided care to the resident, they confirmed the resident demonstrated pain when they provided care to the resident, indicated

they felt the pain the resident experienced was significant and reported this information to the registered staff.

A review of the clinical record and a Registered Nurse (RN) confirmed that a strategy to manage pain when care was provided to the resident had not been put in place.

ii. Following an assessment by the Physician, they identified the resident experienced significant pain and ordered the resident to receive a narcotic pain medication every four hours as needed.

The clinical record and the resident's family member confirmed they reported to a RPN that the resident had pain and needed medication.

The RPN responded by administering a mild pain medication, not the narcotic medication ordered by the Physician. The RPN acknowledged they had not documented an assessment of the resident, were unable to explain their rationale for not administering the medication ordered by the physician and did not return to assess the effectiveness of the medication in reducing the pain the resident experienced.

The Medication Administration Record (MAR) indicated when the RPN administered the mild pain medication, they had identified the resident's pain was moderately high.

The clinical record and the MAR confirmed that no pain assessments had been completed and no further medication had been administered to manage the resident's pain over the following 23-hour period.

3. A resident's right to proper care consistent with their needs was not respected when X-Rays order by the Physician to determine the extent of the injuries sustained by the resident were processed in a timely manner.

   The Physician saw the resident, noted the pain the resident experienced and ordered X-rays to be taken to determine possible injuries sustained during an incident.

   The clinical record indicated the requisitions for the X-rays had not been processed immediately and were processed in excess of 15 hours after the Physician had ordered the imaging to be done.

   A RN confirmed that only RNs were allowed to process imaging requisitions, acknowledged that the almost 15-hour delay in processing the Physician's order was unacceptable and the RNs who worked the day and evening shifts should have processed those orders.

X-Ray reports faxed to the home confirmed the resident had sustained injuries.

The delay by RNs in processing the Physician's orders resulted in the physician, staff and family not being aware of the injuries sustained by the resident for approximately 30 hours.

B. The licensee failed to ensure that a resident's right to have care provided based on their needs was fully respected and promoted when they failed to ensure staff followed the licensee's policies, procedures and expectations related to the following:

1. The licensee did not ensure staff followed directions included in the "Falls Prevention Program" identified as MP00-002, last revised May 2, 2022, which directed the following:

- It was the "responsibility of the Director of Resident Care/Assistant Director of Resident Care to oversee the policy within the home and to complete a thorough analysis of falls to mitigate future falls".

  During the inspection it was identified that staff had not complied with the directions in the policy and an analysis of the fall incident that involved a resident had not been completed.

- It was the "responsibility of registered staff to complete a thorough assessment of the resident following a fall, complete RNAO Post Fall Assessment Order Set and document as required".

  It was identified that following a fall that resulted in a resident experiencing pain and a change in their level of consciousness, staff had not completed an assessment that was specifically designed for falls, when they had not completed the RNAO Post Fall Assessment Order Set.

- It was the "responsibility of registered staff to monitor each shift if changes need to be made to the resident plan of care".

  It was identified that following a fall a resident demonstrated significant changes in their care needs and registered had not made changes to the resident's plan of care to reflect the change in care direction for staff.

2. The licensee did not ensure staff followed directions included in the" Pain Assessment and Management Program" identified as MP00-004, last revised on April 11, 2022, which directed the following:

- "All residents with significant changes will have their pain assessed using the Pain Assessment on Point Click Care (PCC)".

  It was identified that a resident experienced significant pain following a fall, that required the use of narcotic pain medication and the identified Pain Assessment on PCC had not been completed. The resident had not been assessed using any of the comprehensive pain assessment documents identified in the licensee's Pain Management Program document.

- "Pain will be documented in Point of Care (POC) (PRN) by PSW".

  It was identified that PSWs reported to registered staff that the resident experienced pain when care was provided due to the injuries they had sustained; however, they had not documented this as required.

3. Did not ensure staff followed directions included in the "Head Injury Routine" policy identified as PCS04-003, last revised on November 1, 2021, which directed the following:

   - "All residents who have suffered a head injury or may have potentially suffered a head injury will be assessed by the registered staff using the Glasgow Coma Scale"

     It was identified that a resident experienced a fall, PSW indicated the resident demonstrated changes in their neurological function, and registered staff documented that the resident's neurological function fluctuated over the following days. The clinical record indicated that registered staff had not assessed the resident using the Glasgow Coma Scale during this period of time.

4. The licensee did not ensure the home leaders followed directions included in the "Complain Process" policy, identified as AD05-001, last revised on February 29, 2022, which directed the following:

   - "All written and verbal complaints will be investigated and resolved within 10 business days of receipt of complaint" and "a record will be kept of any response provided to the complainant".

     It was identified that two resident family members met with the Administrator and the DRC to express concerns they had about the care of the resident. There was no record to indicate the complaints raised were investigated and it was confirmed that the family members had not received a response to their concerns.

The resident's right to receive proper care was not fully respected and promoted when staff did not provide them with proper care based on their demonstrated needs and when the licensee failed to ensure staff complied with the directions for care set out in the licensee's policies and procedures.

Sources: the resident's progress notes and assessment tab in the electronic record, X-Ray Report, Medication Administration Record, Falls Prevention Program policy, Pain Assessment and Management Program policy, Head Injury Routine policy, Complaint Process policy and interviews with two family members, PSWs, a RPN, RNs, the Physician, the DRC, and the Administrator.

This order must be complied with by November 30, 2022

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.