



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 11, 2013	2013_205129_0001	H-000014-13	Critical Incident System

Licensee/Titulaire de permis

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

Long-Term Care Home/Foyer de soins de longue durée

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 21, 22 and 23, 2013

During the course of the inspection, the inspector(s) spoke with residents, regulated and unregulated nursing staff, physiotherapy staff, Assistant Director of Care and the Administrator in relation to Log #H-000014-13.

During the course of the inspection, the inspector(s) observed residents, reviewed clinical records and reviewed the homes policies and procedures

The following Inspection Protocols were used during this inspection:
Pain

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



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Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

- 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; 2007, c. 8, s. 6 (1).**
 - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
 - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

Findings/Faits saillants :



1. The licensee did not ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, in relation to the following: [6(1)(c)]

a) Resident #1 has mobility challenge as a result of a medical condition and the written plan of care did not set out clear directions for staff providing direct care in relation to positioning or actions taken to ensure the resident was protected from injury. Staff confirmed that the plan of care does not provide clear direction related to the care required by the resident or safety measure to be put in place to prevent injury. The resident suffered a injury while being transported in the home that required transfer and treatment in hospital.

b) Resident #2 was receiving treatment to manage pain, however, the plan of care did not set out clear directions for staff providing direct care in relation to positioning, support or modifications required in caring for the resident related to a painful body part. Staff confirmed that Personal Support Workers (PSWs) use the kardex in the Point of Care computerized system to direct the personal care to be provided to residents and that the PSWs did not have access to the full care plan. Staff also confirmed that the kardex does not provide information to the PSWs with respect to the part of the body that is causing the resident pain and does not provide directions to staff related to the actions to take to position, support or protect this body part. During the course of this inspection the resident confirmed that pain was an increasing an issue.

c) Resident #3 sustained an injury subsequent to a fall and the written plan of care provided conflicting directions for care related to ambulation and transfers. The therapy portion of the plan of care indicated the resident requires two staff to ambulate, the resident uses an aid with the assistance of two staff to walk and the resident requires the assistance of two staff to transfer out of bed. The transferring section of the nursing care plan indicated the resident is to be supervised for the first transfer of the day only, the resident ambulates independently with an aid for walking and will use the toilet independently. Staff also confirmed that the plan of care does not provide clear direction related to the assistance required by the resident for bed mobility. [s. 6. (1) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care



Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure the plan of care was based on, at a minimum, interdisciplinary assessment of pain, related to the following: [26(3)10]

- a) Resident #1 experienced pain on an identified date as a result of an injury that occurred while the resident was being transported in a wheelchair. Staff and clinical record documentation confirmed that an interdisciplinary pain assessment was not completed when this injury occurred, nor when the resident continued to experience pain and was ordered to receive a narcotic analgesic to manage this pain, nor when the resident returned to the home following assessment and treatment in hospital for this injury and was ordered to receive a stronger narcotic analgesic or at any time up to and including the time of this inspection. Therapy staff also confirmed that they did not receive a referral to assess the resident based on the injury and the pain being experienced by the resident and did not complete a pain assessment for this resident.
- b) Resident #2 had been receiving a narcotic analgesic to manage a pain. Staff and the clinical record confirmed that the resident had been receiving this medication for a lengthy period of time, however, an interdisciplinary pain assessment was not completed. Staff and clinical documentation also confirmed that the resident began to experience an increase in pain, identified by the resident as being severe in nature. At this time the resident began to receive as necessary doses of the narcotic analgesic in addition to the regularly scheduled medication; however a pain assessment was not completed. As a result of the increased pain being experienced by the resident the resident was transferred to the hospital. Therapy staff confirmed that the resident had been experiencing increased pain and would often refuse to participate in the therapy program, however, a pain assessment was not completed.
- c) Resident #3 experienced pain subsequent to a fall that resulted in an injury and transfer to hospital for assessment and treatment. Staff and clinical documentation confirmed that an interdisciplinary pain assessment was not completed for this resident despite the resident receiving narcotic analgesic medication to manage pain on 22 identified dates. The resident continued to experience pain at the time of this inspection. [s. 26. (3) 10.]



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Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :



1. The licensee did not ensure that when a resident is taking any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level, in relation to the following: [134

(a)]

a) Resident #1 received a narcotic analgesic three times on each of four identified consecutive days, however, the resident's response to or the effectiveness of this medication was not monitored or documented in the clinical record. Staff indicated that it is the expectation that the resident's response to the medication and the effectiveness of the medication is to be documented within the electronic medication system used by the home and in the progress notes section of the resident's clinical record. Staff and the clinical record confirmed that the response of the resident and the effectiveness of this medication was not documented following the administration of this medication on the identified dates. The resident continued to experience an increase in the intensity of pain at the time of this inspection.

b) The effectiveness of a regularly scheduled narcotic analgesic being administered to resident #2 in order to manage pain was not documented. Staff and clinical documentation confirmed that the resident had been receiving this medication for a long period of time, a pain assessment was not completed and the Minimum Data Set (MDS) reassessment of this resident completed quarterly did not include an evaluation of the effectiveness of this treatment in managing the resident's pain. [s. 134. (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :



1. The licensee did not ensure that the right of every resident to be properly cared for in a manner consistent with her needs was fully respected and promoted, in regards to the following: [3(1)4]

Resident # 1's right to be properly cared for in a manner consistent with the identified needs was not fully respected and promoted when the resident experienced an injury on an identified date.

a) The resident did not receive treatment for this injury for 10 days following this injury when the resident was transferred to the hospital. A Registered staff member who was in close proximity to the resident when this injury occurred and was aware that something had caused the resident to experience pain, confirmed that she did not assess the resident for injury nor was this incident documented in the clinical record so staff on the following shift could monitor and assess the resident. A second registered staff member indicated the resident was assessed the day following the injury when care staff reported the resident was experiencing pain; however this staff member confirmed that the resident was not completely assessed, the injury to the resident and the source of the pain was not identified. Staff confirmed that two days following the above noted assessment care staff indicated the resident was still experiencing pain, the resident was assessed and injuries identified at that time that lead the registered staff person to suspect that the resident had sustained an injury that may require treatment in hospital. This staff person indicated that she sent a fax to the resident's physician indicating her suspicion and requested an order for a diagnostic procedure; however she confirmed that the physician did not respond to the fax and staff did not follow-up with the physician to ensure the resident was assessed and treated. The physician visited the home three days after being contacted by the home and ordered this diagnostic procedure, but did not make a note that the resident had been assessed. Staff processed a request for the this procedure; however staff confirmed that they did not contact the service provider in order to ensure this diagnostic procedure was completed in a timely manner and the resident did not receive this procedure for three more days. The results of this procedure confirmed that the resident had suffered an injury that required transfer to the hospital for assessment and treatment.

b) Staff and clinical documentation also confirmed that although the resident complained of pain, care to manage this pain was not provided from the time of the injury and subsequent to the physician ordering a narcotic analgesic for pain management.

c) As a result of the physician's visit the resident was ordered to receive a narcotic analgesic three times a day for 14 days. Staff and the electronic medication



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documentation system used by the home confirmed that the resident did not receive this or any other additional pain medication for three days because the medication was not available in the home. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the right to be properly cared for in a manner consistent with his or her needs is fully respected and promoted for all residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :



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1. The licensee did not ensure that where the Act or this Regulations requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that staff in the home comply with those directions, in relation to the following: [8(1) (b)]

a) Staff in the home did not comply with the homes policy related to communication in the Nursing Department. This policy identified as [Change of shift Report #03-01-02-dated January 2013] directed that any changes in a resident's condition, as well as any other significant information should be promptly reported to other staff members in charge of the resident's care. Staff confirmed that the injury that occurred to resident #1, the subsequent complaints of pain and the assessment that occurred on the day following the injury was not reported to oncoming staff. This information was also not recorded in the clinical record and as a result did not auto populated into the computerized 24-Hour Report used in the home. The home confirmed that it is the expectation that staff review the computerized 24-Hour Report at the beginning of each scheduled shift.

b) Staff in the home did not comply with the homes policy related to resident care assessment and planning. This policy identified as [Assessment of Resident Care: Ongoing and Quarterly Review #03-01-06 dated January 2013], directed that care planning is an ongoing process and each resident's care and service needs are reassessed whenever there is a change in the resident's health status, needs or abilities. Staff confirmed that an injury that occurred to resident #1 caused the resident to experience pain and that the resident was not assessed at that time to determine the extent of the injury.

c) Staff in the home did not comply with the homes policy related to pain management and assessment. This policy identified as [Pain Management Assessment # 05-01-04 dated January 2013] directed staff that each resident who experiences pain/discomfort is to receive care to manage the pain/discomfort. Staff and the clinical record confirmed that resident #1 did not receive additional care to manage pain, following an injury that caused this resident to experience pain.

d) Staff in the home did not comply with the homes policy related to pain assessment. This policy identified as [Pain Assessment #05-1-04A dated January 2013] directed staff that:

- All residents are to be routinely screened for the presence of pain and staff are to complete an appropriate comprehensive pain assessment. This policy identifies that there are two assessment tools to be used – one for a resident who is cognitively alert and a separate one for residents who are cognitively impaired or non-communicative. Staff and the clinical record confirmed that this policy was not complied with when



neither of these two assessment tools were used to assess resident #1, #2 or #3 when they demonstrated that they were experiencing pain.

- If pain is indicated, a Pain Management Effectiveness Flow sheet is to be inserted in the front of the resident's Medication Record (MAR) and is to be completed as per the policy. Staff and the clinical record confirmed that this policy was not complied with when pain management flow sheets were not used for resident #1 who indicated pain and had suffered an injury that would have been painful, resident #2 who was receiving a regularly scheduled narcotic analgesic for pain and complained of increasing levels of pain and #3 who complained of pain and suffered an injury that would have been painful. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that staff comply with those directions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

- 1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
- 2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
- 3. Behaviour management. 2007, c. 8, s. 76. (7).**
- 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
- 5. Palliative care. 2007, c. 8, s. 76. (7).**
- 6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**



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Findings/Faits saillants :

1. The licensee did not ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, annual retraining in accordance with O.Reg 79/10, s. 221(2)1, in the area of pain management in accordance with O.Reg 79/10, s.221(1)4, in relation to the following: [76(7)6]

The Director of Care confirmed that none of the 161 staff in the home who provide direct care to residents were provided with retraining in the area of pain management, including recognition of specific and non-specific signs of pain in 2011, 2012 or 2013 up to the time of this inspection. [s. 76. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that all staff who provide direct care to residents receive annual retraining in the area of pain management, to be implemented voluntarily.

Issued on this 12th day of April, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Phyllis Hiltz-Bontje



**Ministry of Health and
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Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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de l'article 154 de la *Loi de 2007 sur les foyers
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Direction de l'amélioration de la performance et de la conformité**

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Name of Inspector (ID #) /

Nom de l'inspecteur (No) : PHYLLIS HILTZ-BONTJE (129)

Inspection No. /

No de l'inspection : 2013_205129_0001

Log No. /

Registre no: H-000014-13

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Apr 11, 2013

Licensee /

Titulaire de permis : HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-
2J3

LTC Home /

Foyer de SLD : HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-
2J3

Name of Administrator /

**Nom de l'administratrice
ou de l'administrateur :** ROSEMARY OKIMI

To HERITAGE GREEN NURSING HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:



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Order # /

Ordre no : 001

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that the written plan of care for each resident sets out clear directions for staff and others providing care based on the identified needs of each resident, including resident #1, #2 and #3.

Grounds / Motifs :



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1. Previously identified as non-compliant with a VPC on August 24, 2011 and May 7, 2012.
2. Three of three resident's care plans reviewed did not set out clear directions for staff and others who provide direct care, in relation to the following:
 - a) The written plan of care for resident #1 did not set out clear directions for staff providing direct care in relation to positioning or actions taken to ensure the resident was protected from injury. Staff confirmed that the plan of care does not provide clear directions related to the positioning, support or safety measures to be put in place based on the identified needs of this resident to prevent injury. The resident suffered an injury while being transported in the home.
 - b) The written plan of care for resident #2 did not set out clear directions for staff, in relation to positioning, support or modifications required in caring for the resident related to a painful body part. The clinical record indicated that the resident received narcotic analgesics on a regular as well as on an irregular basis for what was described as severe pain. Staff confirmed that Personal Support Workers (PSWs) use the kardex in the Point of Care computerized system to direct the personal care to be provided to residents and that the PSWs do not have access to the entire care plan. Staff also confirmed that the kardex does not provide information to the PSWs with respect to the part of the body that is causing the resident pain and does not provide directions to staff related to the actions to take in order to position, support or protect the body part. Physiotherapy staff indicated that due to pain, the lack of positioning and functional support, the resident has experienced a significant decrease in the ability to move this body part. During this inspection the resident confirmed that the pain was unbearable.
 - c) The written plan of care for resident #3 provided conflicting directions for care related to ambulation and transfers following an injury that limited movement. The therapy portion of the plan of care indicated the resident required two staff to ambulate, the resident used an aid to walk with the assistance of two people and two staff were to assist the resident in the transfer out of bed; however, the transferring portion of the nursing care plan indicated the resident is to be supervised for the first transfer of the day only, the resident ambulates independently using an aid and will toilet independently. The resident remains at further risk of falling if care is not provided to ensures safe transfers and ambulation. (129)



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Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

May 30, 2013



**Ministry of Health and
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Order(s) of the Inspector
Pursuant to section 153 and/or
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Order # /

Ordre no : 002

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :



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O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall complete interdisciplinary pain assessments for each resident experiencing pain, including resident #1, #2 and #3 and shall ensure the care decisions resulting from those assessments are included in the written plan of care.



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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1. Three of three residents reviewed who demonstrated they were experiencing pain did not have an interdisciplinary pain assessment completed.
 - a) The plan of care for resident #1 was not based on an interdisciplinary assessment related to pain. Staff and clinical record documentation confirmed that a pain assessment was not completed when this resident identified pain as a result of an injury on an identified date, nor when the resident received a narcotic analgesic medication to manage the pain eight days following the injury, nor when the resident returned from hospital after being assessed and treated for injuries and was ordered to receive a stronger narcotic or at any time up to and including the time of this inspection. Therapy staff confirmed that they did not receive a referral to assess the resident based on the injuries and the pain being experienced by the resident and have not completed a pain assessment for this resident.
 - b) The plan of care for resident # 2 was not based on an interdisciplinary assessment related to pain. Staff and the clinical record confirmed that the resident was ordered to and had been receiving a regularly scheduled narcotic analgesic for a lengthy period of time for the management of pain; however a pain assessment had not been completed. Staff and clinical documentation also confirmed that the resident began to experience an increase in pain identified by the resident as being severe in nature. At this time the resident began to receive as necessary doses of the narcotic analgesic in addition to the regularly schedule medication; however a pain assessment was not completed. The resident was transferred to the hospital due to increasing levels of pain and staff confirmed that a pain assessment was not completed for this resident. Therapy staff confirmed that the resident had been experiencing increased pain and would often refuse to participate in the therapy programs; however, a pain assessment was not completed.
 - c) The plan of care for resident #3 was not based on an interdisciplinary assessment related to pain. The resident sustained injuries as a result of a fall on an identified date, was transferred to the hospital for treatment of these injuries and returned to the home. Staff and clinical documentation confirmed that an interdisciplinary pain assessment was not completed for this resident despite the resident receiving narcotic analgesic to manage pain she was experiencing on 22 identified dates. At the time of this inspection the resident disclosed that pain remained an issue. (129)



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**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

May 15, 2013



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

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Order # / Ordre no : 003	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)
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Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including
psychotropic drugs, there is monitoring and documentation of the resident's
response and the effectiveness of the drugs appropriate to the risk level of the
drugs;
(b) appropriate actions are taken in response to any medication incident
involving a resident and any adverse drug reaction to a drug or combination of
drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's
drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee shall monitor all residents receiving medication to manage pain,
including residents #1 and #2 and shall document both each resident's response
to the pain medication being given and the effectiveness of the medication being
administered.

Grounds / Motifs :



**Ministry of Health and
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1. Two of three residents reviewed who were receiving medication to manage pain were not monitored related to their responses to the medication and the effectiveness of the medication was not documented, in relation to the following:
- a) Resident #1's response to or the effectiveness of a narcotic analgesic administered to the resident three times a day on four identified dates in order to manage pain was not documented. Staff and the clinical record confirmed that the response of the resident and the effectiveness of this medication in the management of pain was not documented following the administration of this medication on the identified dates.
 - b) The effectiveness of a regularly scheduled narcotic analgesic being administered to resident #2's in order to manage pain was not documented. Staff and clinical documentation confirmed that the resident had been receiving this medication for a long period of time and there was no evidence in the clinical record that the effectiveness of this medication had been documented. The resident continued to experience pain and at the time of this inspection.
- (129)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : May 15, 2013



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance
Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.



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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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de soins de longue durée*, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la
conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 11th day of April, 2013

Signature of Inspector /
Signature de l'inspecteur : *Phyllis Hiltz-Bontje*

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

Service Area Office /
Bureau régional de services : Hamilton Service Area Office