Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 10, 2016	2016_339617_0004	021676-15	Follow up

Licensee/Titulaire de permis

CVH (No.2) LP
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

BIRCHWOOD TERRACE
237 Lakeview Drive R. R. #1 KENORA ON P9N 4J7

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

SHEILA CLARK (617), JENNIFER KOSS (616)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 18, 19, 20, 21, 22, 2016

This Follow Up inspection is related to the following compliance orders issued to the home:
- bed rail assessment, Intake #021676-15,
- sufficient staffing, Intake #0021894-15,
- resident bill of rights, care plan, resident staff communication system, mandatory reporting of abuse, Intake #033849-15.

This inspection was conducted concurrently with Complaint inspection #2016_339617_0005 and Critical Incident inspection #2016_339617_0003.

Findings of non-compliance regarding plan of care, LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7), found in the Complaint Inspection and mandatory reporting, LTCHA, 2007, S. O. 2007, c. 8, s. 24 (1), found in the Critical Incident inspection, are issued in this Follow Up Report.

During the course of the inspection, the inspector(s) spoke with Administrator (AD), Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Resident Services Coordinator (RSC), Environmental Services Manager (ESM), Food Services Manager (FSM), Registered Dietitian (RD), Housekeepers (HSKs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), residents and family.

Observations were made of the home areas, meal services, and the provision of care and services to residents during the inspection. The home's policies and procedures and resident health records were reviewed.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_339617_0008	617
O.Reg 79/10 s. 17. (1)	CO #004	2015_246196_0011	616
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2015_246196_0011	616
O.Reg 79/10 s. 31. (3)	CO #001	2015_339617_0009	617
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #002	2015_246196_0011	616

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

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A complaint was submitted to the Director in September 2015, related to an altercation between residents #012 and #018. The altercation resulted in injury to resident #012. The altercation was documented in the resident's chart that it occurred in September 2015.

During an interview, the DOC explained they were aware of the incident in September 2015, but had no knowledge of resident #012's injury. They confirmed they did not report the incident to the Director immediately but should have.

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately reported the information upon which it was based to the Director.

A Critical Incident (CI) report was submitted to the Director in December 2015, regarding neglect of resident #004, four days after the incident occurred.

Inspector #617 reviewed the home’s investigation notes which identified that Registered Staff documented a witnessed account of the incident when it occurred in December 2015. Resident #004 rang their call bell several times for assistance and a PSW answered the bells but did not provide the requested assistance to the resident.

Inspector #617 reviewed the Extendicare operations policy titled, "Resident Abuse-Staff to Resident-#OPR-02-02-04" last revised September 2015, which indicated all staff in the home were to immediately report any suspected or witnessed abuse, incompetent treatment or care, or misappropriation of funds to the Administrator, Director of Care, or their designate as required by provincial legislation and jurisdictional requirements.

Inspector #617 interviewed the DOC who confirmed that the report of the suspected neglect of resident #004 was reported late to the Director and that the registered staff should have notified administration immediately as an expectation of the home's policy.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to residents' #002 and #006, as specified in the plan.

A complaint was submitted to the Director in October 2015, regarding physician's orders not followed through, and missed medication administration to residents.

Inspector #616 reviewed the Medication Administration Records (MAR) and physician's orders for resident's #002 and #006.

A Physician order in resident #002's health record for November 2015, prescribed, specific vital signs to be measured daily. The November 2015 MAR was reviewed by the Inspector, which indicated the specific vital sign measurements, were to be obtained every morning.

Documentation for the specific vital sign measurements was missing on seven occurrences in the MAR for November 2015.

Registered Nurse (RN) #110, reviewed the order dated in November 2015, and the November 2015, MAR with the Inspector. They explained the incomplete documentation

in the MAR indicated the specific vital sign measurement was not obtained as per the order in resident #002's plan of care and it should have been completed.

Inspector #616 reviewed resident #006’s December 2015 MAR which revealed documentation for all medications scheduled to be administered at every morning was missing on one day in December 2015. There were nine medications that did not have documented administration times.

The Inspector reviewed progress notes for December 2015, and noted there was no documentation related to the missed medication.

During an interview with RN #110 they stated that the one day in December 2015, when the medication administration was not signed in the MARs by registered staff, indicated that the medication was not administered as per resident #006's plan of care.

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A complaint was submitted to the Director in September 2015, related to the nutrition and hydration status of resident #001. Resident #001 no longer resides in the home.

Resident #001's archived health record was reviewed by Inspector #616 that included a care plan dated for July 2015, progress notes, a Resident Assessment Instrument Minimum Data Set (RAIMDS) assessment, nutrition assessments, and food and fluid intake records for the months of July and August 2015.

The care plan for resident #001, identified they were at a high nutritional risk related to their disease process. The care plan indicated the resident #001 was to have received specific interventions related to the type of diet offered, and assistance required.

Further, the care plan identified that resident #001 had a potential for dehydration related to their increased health care needs. Specific nursing interventions were indicate in resident #001's care plan to monitor, observe and report any symptoms of dehydration.

A specific hydration goal was identified in the care plan for resident #001 and was determined by the Registered Dietitian (RD).

The food and fluid intake records for resident #001 revealed that their fluid intake was

less than the care planned goal 90 per cent of the time in July 2015 and 70 per cent of the time in August 2015.

As per the home’s policy titled, "Food and Fluid Intake Monitoring-#RESI-05-02-05" last revised September 2014, care staff were to have monitored and documented the resident’s nutritional intake. Registered staff were directed to review resident food and fluid intake records daily. The policy further instructed registered staff to refer a resident to the RD if the resident had consumed 50 per cent or less from all meals for three or more days, or, refused nutritional interventions for three consecutive days.

Throughout July and August, documentation of resident #001's nutritional intake was incomplete on 52 per cent of the time in July 2015 and 41 per cent of the time in August. Resident #001's documented nutritional intake was less than 50 per cent on more than three days in August 2015. A referral to the RD was sent to the RD later in August 2015. The RD stated they should have received a referral for food intake less than 50 per cent immediately after it occurred at the beginning of August 2015, but they did not.

As per resident #001's plan of care and the home's policy, their nutritional intake was to have been monitored and documented by care staff and reviewed by registered staff daily. During an interview with the DOC, they confirmed that staff did not document all of resident #001’s nutritional intakes throughout July and August 2015 and should have. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the MOHLTC related to responsive behaviour of resident #012 and staff not following the plan of care related to responsive behaviours.

The resident's health record was reviewed by Inspector #616 that included progress notes, documentation, Resident Assessment Instrument Minimum Data Set (RAI-MDS), the care plan, daily care flow sheets, and Consultation records.

A referral to a Resource Consultant regarding resident #012's responsive behaviours was reviewed and it indicated that the resident was referred to them and had a consult in August 2015.

The progress notes indicated that a summary of the Consultant's recommendations was

reported to staff in September 2015, which included but was not limited to ensuring that specific interventions were put in place to reduce the number of occurrences and prevent resident #012's responsive behaviour from affecting other residents living in the home.

On January 20, 21, and 22, 2016, Inspector #616 observed the specific environmental intervention that was to be put in place to prevent resident #012's responsive behaviour from affecting other residents. Over that three day period, 27 observations revealed that on 25 occasions, or 93 per cent of the time, the environmental intervention was not put in place.

During an interview with Registered Practical Nurse (RPN), they stated that resident #012's known responsive behaviour was addressed by a consultant with recommendations. They located the recommendations filed in resident #012's chart, and confirmed there was no copy of the consultant's recommendations available in the PSW flow sheet binder. RPN #115 confirmed that the recommended environmental interventions at the time of the interview, was not in accordance to the resident's plan of care.

The home's policy titled "Responsive Behaviour-#09-05-01" last revised September 2010, instructed all staff who provided care to residents are required to be familiar with the resident plan of care, the specific interventions related to behaviours and be consistent in the application and implementation of these interventions.

Documentation of the resident's responsive behaviour was reviewed on the PSW daily flow sheets for the months of December 2015 and January 2016. Documentation was incomplete on 18 of 31 days in December and incomplete on 14 of 19 days in January 2016.

The DOC explained that staff were expected to complete the documentation related to resident #012's responsive behaviour and indicated that this did not occur and should have as per plan of care.

4. The licensee failed to ensure that the provision of the care set out in resident #012's plan of care was documented.

A complaint was received by the Director in September 2015, related to the care of resident #012, specifically regarding personal care.

Inspector #616 observed resident #012 to be not groomed appropriately on a day during the inspection.

The current care plan identified that resident #012 was to have received assistance by staff in the provision of personal care.

Inspector #616 reviewed resident #012's daily flow sheets for December 2015, and January 2015, related to the provision of personal care.

Throughout the review period, Inspector #616 determined that required documentation of resident #012's provision of care by the PSWs was incomplete 50 to 78 per cent of the time.

During an interview, PSW #103 stated it was the responsibility of the PSW who provided care to document that care in the daily flow sheet. PSW #103 further stated that when residents refuse care, the PSW was to report that to the registered staff, and then document the refusal in the daily flow sheets.

During an interview PSW #103 and the DOC both confirmed that the incomplete documentation on the daily flow sheets indicated that the care related to personal care had not been provided to resident #012 as per their plan of care.

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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Inspector #617 interviewed the AD and the DOC who reported that part of the staffing mix for the home were a Registered Nurse (RN) on duty and present in the building at all times. The RN shifts were 12 hr day (D) and night (N) shifts.

On January 22, 2016, Inspector #617 interviewed Registered Nurse (RN), who reported that the home had been short many RN shifts over the months of December 2015, and January 2016. An interview with Registered Practical Nurse (RPN), reported that RN vacant shifts were replaced with RPNs, and confirmed that they had picked up many shifts as overtime for RN shortages over the months of December 2015, and January 2016.

The AD sent Inspector #617 an email on January 26, 2016, of the home's contingency plan for when a RN shift could not be covered, titled "Working Short-Registered Staff", last revised September 5, 2013. The plan stated that when a vacant RN shift occurred and was not able to be replaced by an RN, a third RPN was to be assigned as the charge registered staff performing modified RN duties. The DOC was to be on call during that time to provide support to the RPN in charge.

The AD submitted and confirmed to Inspector #617 via scanned email on January 26, 2016, a list of the dates and shifts the home did not have an RN on duty and was replaced by an RPN:
December 19, 2015 - N
December 25, 2015 - D
December 28, 2015 - D
December 28, 2015 - N
December 29, 2015 - N
December 30, 2015 - D
December 31, 2015 - D
January 1, 2016 - D
January 3, 2016 - D
January 6, 2016 - D

On January 25, 2016, the DOC, confirmed via email that the RN shortages for December 2015, and January 2016, were related to schedule vacancies, not emergencies.

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 to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

Issued on this 15th day of March, 2016

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

Original report signed by the inspector.

Ontario

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

Ministére 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHEILA CLARK (617), JENNIFER KOSS (616)
Inspection No. / No de l'inspection :	2016_339617_0004
Log No. / Registre no:	021676-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 10, 2016
Licensee / Titulaire de permis :	CVH (No.2) LP c/o Southbridge Care Homes, 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	BIRCHWOOD TERRACE 237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	WENDY SARFI

To CVH (No.2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_246196_0011, CO #005;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall:

a) Ensure any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director.

b) Ensure training and retraining for all staff includes the mandatory duty to report all alleged or suspected abuse or neglect of residents and to maintain a record of all staff who completed the training.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately reported the information upon which it was based to the Director.

A Critical Incident (CI) report was submitted to the Director in December 2015, regarding neglect of resident #004, four days after the incident occurred.

Inspector #617 reviewed the home's investigation notes which identified that Registered Staff documented a witnessed account of the incident when it occurred in December 2015. Resident #004 rang their call bell several times for assistance and a PSW answered the bells but did not provide the requested assistance to the resident.

Inspector #617 reviewed the Extendicare operations policy titled, "Resident Abuse-Staff to Resident-#OPR-02-02-04" last revised September 2015, which indicated all staff in the home were to immediately report any suspected or witnessed abuse, incompetent treatment or care, or misappropriation of funds to the Administrator, Director of Care, or their designate as required by provincial legislation and jurisdictional requirements.
(617)

2. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A complaint was submitted to the Director in September 2015, related to an altercation between residents #012 and #018. The altercation resulted in injury to resident #012. The altercation was documented in the resident's chart that it occurred in September 2015.

During an interview, the DOC explained they were aware of the incident in September 2015, but had no knowledge of resident #012's injury. They confirmed they did not report the incident to the Director immediately but should have.

The scope of this issue was a pattern of residents involved in the Critical Incident Reports that were not reported immediately to the Director. There was a previous on-going compliance order issued related to this. The severity of was determined to be potential for actual harm to the health, safety and well-being of the resident.

Previous non-compliance specific to LTCHA 2007,S.O.2007, c.8, s.24 was identified from the following previous inspections:

- July 2015 Resident Quality Inspection #2015_246196_0011 issued CO
- July 2014 Critical Incident Inspection #2014_211106_0012 issued VPC
- April 2014 Complaint Inspection #2014_333577_0005 issued VPC
- May 2013 Critical Incident Inspeciton #2013_211106_0008 issued VPC (616)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 01, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_246196_0011, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall:

a) Ensure that the care set out in the plan of care regarding medication administration and any ordered assessments is provided to residents #002, #006, and all residents.

b) Ensure that the care set out in the plan of care regarding food and fluid intake for all residents is audited to ensure that required monitoring and documentation is completed.

c) Ensure the care set out in the plan of care regarding strategies to prevent responsive behaviour for resident #012 and all residents is provided.

d) Ensure the care set out in the plan of care regarding personal care needs for resident #012 and all residents is provided.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the MOHLTC related to responsive behaviour of resident #012 and staff not following the plan of care related to responsive behaviours.

The resident's health record was reviewed by Inspector #616 that included

progress notes, documentation, Resident Assessment Instrument Minimum Data Set (RAI-MDS), the care plan, daily care flow sheets, and Consultation records.

A referral to a Resource Consultant regarding resident #012's responsive behaviours was reviewed and it indicated that the resident was referred to them and had a consult in August 2015.

The progress notes indicated that a summary of the Consultant's recommendations was reported to staff in September 2015, which included but was not limited to ensuring that specific interventions were put in place to reduce the number of occurrences and prevent resident #012's responsive behaviour from affecting other residents living in the home.

On January 20, 21, and 22, 2016, Inspector #616 observed the specific environmental intervention that was to be put in place to prevent resident #012's responsive behaviour from affecting other residents. Over that three day period, 27 observations revealed that on 25 occasions, or 93 per cent of the time, the environmental intervention was not put in place.

During an interview with Registered Practical Nurse (RPN), they stated that resident #012's known responsive behaviour was addressed by a consultant with recommendations. They located the recommendations filed in resident #012's chart, and confirmed there was no copy of the consultant's recommendations available in the PSW flow sheet binder. RPN #115 confirmed that the recommended environmental interventions at the time of the interview, was not in accordance to the resident's plan of care.

The home's policy titled "Responsive Behaviour-#09-05-01" last revised September 2010, instructed all staff who provided care to residents are required to be familiar with the resident plan of care, the specific interventions related to behaviours and be consistent in the application and implementation of these interventions.

Documentation of the resident's responsive behaviour was reviewed on the PSW daily flow sheets for the months of December 2015 and January 2016. Documentation was incomplete on 18 of 31 days in December and incomplete on 14 of 19 days in January 2016.

The DOC explained that staff were expected to complete the documentation

related to resident #012's responsive behaviour and indicated that this did not occur and should have as per plan of care. (616)

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A complaint was submitted to the Director in September 2015, related to the nutrition and hydration status of resident #001. Resident #001 no longer resides in the home.

Resident #001's archived health record was reviewed by Inspector #616 that included a care plan dated for July 2015, progress notes, a Resident Assessment Instrument Minimum Data Set (RAIMDS) assessment, nutrition assessments, and food and fluid intake records for the months of July and August 2015.

The care plan for resident #001, identified they were at a high nutritional risk related to their disease process. The care plan indicated the resident #001 was to have received specific interventions related to the type of diet offered, and assistance required.

Further, the care plan identified that resident #001 had a potential for dehydration related to their increased health care needs. Specific nursing interventions were indicate in resident #001's care plan to monitor, observe and report any symptoms of dehydration.

A specific hydration goal was identified in the care plan for resident #001 and was determined by the Registered Dietitian (RD).

The food and fluid intake records for resident #001 revealed that their fluid intake was less than the care planned goal 90 per cent of the time in July 2015 and 70 per cent of the time in August 2015.

As per the home's policy titled, "Food and Fluid Intake Monitoring-#RESI-05-02-05" last revised September 2014, care staff were to have monitored and documented the resident's nutritional intake. Registered staff were directed to review resident food and fluid intake records daily. The policy further instructed registered staff to refer a resident to the RD if the resident had consumed 50 per cent or less from all meals for three or more days, or, refused nutritional

interventions for three consecutive days.

Throughout July and August, documentation of resident #001's nutritional intake was incomplete on 52 per cent of the time in July 2015 and 41 per cent of the time in August. Resident #001's documented nutritional intake was less than 50 per cent on more than three days in August 2015. A referral to the RD was sent to the RD later in August 2015. The RD stated they should have received a referral for food intake less than 50 per cent immediately after it occurred at the beginning of August 2015, but they did not.

As per resident #001's plan of care and the home's policy, their nutritional intake was to have been monitored and documented by care staff and reviewed by registered staff daily. During an interview with the DOC, they confirmed that staff did not document all of resident #001's nutritional intakes throughout July and August 2015 and should have. (616)

3. The licensee failed to ensure that the care set out in the plan of care was provided to residents' #002 and #006, as specified in the plan.

A complaint was submitted to the Director in October 2015, regarding physician's orders not followed through, and missed medication administration to residents.

Inspector #616 reviewed the Medication Administration Records (MAR) and physician's orders for resident's #002 and #006.

A Physician order in resident #002's health record for November 2015, prescribed, specific vital signs to be measured daily. The November 2015 MAR was reviewed by the Inspector, which indicated the specific vital sign measurements, were to be obtained every morning.

Documentation for the specific vital sign measurements was missing on seven occurrences in the MAR for November 2015.

Registered Nurse (RN) #110, reviewed the order dated in November 2015, and the November 2015, MAR with the Inspector. They explained the incomplete documentation in the MAR indicated the specific vital sign measurement was not obtained as per the order in resident #002's plan of care and it should have been completed.

Inspector #616 reviewed resident #006's December 2015 MAR which revealed documentation for all medications scheduled to be administered at every morning was missing on one day in December 2015. There were nine medications that did not have documented administration times.

The Inspector reviewed progress notes for December 2015, and noted there was no documentation related to the missed medication.

During an interview with RN #110 they stated that the one day in December 2015, when the medication administration was not signed in the MARs by registered staff, indicated that the medication was not administered as per resident #006's plan of care.

The scope of this issue was a pattern of residents in which care was not provided as set out in their care plans. There was a previous on-going compliance order issued related to this. The severity of was determined to be potential for actual harm to the health, safety and well-being of the resident.

Previous non-compliance specific to LTCHA 2007, S.O.2007, c.8, s6 was identified during the following inspections:
- July 2015 Resident Quality Inspection #2015_246196_0011 issued CO
- August 2014 Resident Quality Inspection #2014_211106_0014 issued VPC
- July 2014 Critical Incident Inspection #2014_211106_0012 issued VPC
- April 2014 Complaint Inspection #2014_333517_0005 issued VPC (616)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 01, 2016

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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
Long-Term Care Inspections 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.

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
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e 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.

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
Inspection de sions de longue durée
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 10th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sheila Clark

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