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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARGOT BURNS-PROUTY (106)
Inspection No. / No de l'inspection :	2013_211106_0008
Log No. / Registre no:	891,138,82,1265,30
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 2, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
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 REVERA LONG TERM CARE INC., 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Order / Ordre :

The licensee shall ensure that a Responsive Behaviours Program is developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Grounds / Motifs :

1. Inspector requested and was provided a written description of the home's responsive behaviour program which consisted of the following documents, "Responsive Behaviours" policy # 09-05-01, "Responsive Episode Debriefing" policy # 09-05-02, and document named "Responsive Behaviours".

Inspector asked staff member # S-100 about the "responsive behaviour record" tool that is indicated to be used by staff in the written program. Staff member # S-100 stated that they were aware of the tool but it is not currently in use and that the Director of Care was going to do an in-service to train staff regarding the tool before it is implemented in the home.

During the entrance interview staff member # S-101 and # S-102 reported that 100% of staff have completed responsive behaviour training in the last 12

months. It was reported the training focused on the ABC Model and Person Centered Care (PCC). An "ABC Behaviour Analysis Chart" for resident #003 was reviewed and staff had filled the form out in an inappropriate manner. In column C, "Consequence (interaction(s)/response(s) to behaviour)", staff had written comments such as "thankful", "have a good day." and "See you later." Incidents where resident #003 had displayed specific responsive behaviours or staff redirecting the resident multiple times on a certian day were not documented on this form, the only comment regarding the day the incidents occurred on the ABC form is "pleasant".

Residents #001, #002, #003 and #004 all display responsive behaviours in the home, the plans of care for these residents were reviewed and they do not contain all the required information that is specified in section 8 of the home's "Responsive Behaviours" policy # 09-05-01, nor have the assessment, reassessment or referral processes as stated in this policy been followed.

During an interview with staff member #S-102 they reported that the Extendicare Responsive Behaviours Program was not fully implemented in the home and prior to February 2013 the home did not have a Revera Responsive Behaviour Program fully implemented in the home.

The licensee failed to ensure that a Responsive Behaviour Program is developed and implemented in accordance with evidence-based practices. (106)

2. One Voluntary Plan of Correction under O. Reg. 79/10, s. 53 (3) (a) has previously been issued in August 2012 during inspection #2012_051106_0015. (106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that resident #002 is protected from abuse by anyone.

Grounds / Motifs :

1. One Voluntary Plan of Correction under LTCHA, 2007, S. O. 2007, c. 8, s. 19 (1) has previously been issued in August 2012 during inspection # 012_051106_0015. (106)

2. A Critical Incident System report submitted to the Ministry of Health and Long-Term Care indicates that, resident #002 was abused by resident #001. Progress notes for resident #001 and #002 indicate that on 2 other occasions resident #002 was abused by resident #001. The licensee failed to ensure that resident #002 was protected from abuse. (106)

3. Two Critical Incident System (CIS) reports submitted to the Ministry of Health and Long-Term Care indicates that resident #002 was abused by resident #003.

Progress notes were reviewed for residents #002 and #003, they indicate that on three different occasions resident #002 was abused by resident #003. The licensee failed to ensure that resident #002 was protected from abuse. (106)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Order # / Ordre no : 003

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 plans of care for residents # 001, 002, 003, 004 and 009 sets out clear directions to staff and others who provide direct care to the residents, in regards to their specific responsive behaviours.

Grounds / Motifs :

1. The health care record for resident #009, including progress notes and plan of care were reviewed by inspector. The progress notes indicated that the resident has displayed specific responsive behaviours on 9 separate occasions during the last 9 months. The plan of care for this resident was reviewed and the section specific to these behaviours does not identify the behaviours, nor does it provide any directions for staff to implement when resident #009 exhibits these behaviours. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. (106)

2. Over a period of 4 months, resident #003 is documented as being witnessed by staff and/or residents as displaying responsive behaviours on numerous different occasions. The plan of care for resident #003 was reviewed and no interventions directing staff how to manage the resident's responsive behaviours were found. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. (106)

3. Three Critical Incident System (CIS) reports submitted to the Ministry of Health and Long-Term Care indicate that resident #001 was found displaying

specific responsive behaviours. Progress notes for resident #001 indicate that on 4 separate occasions the resident displayed specific responsive behaviours. The plan of care for resident #001 was reviewed and there were no clear directions found on how staff are to manage the resident's specific responsive behaviours. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. (106)

4. The progress notes for resident #002 were reviewed. During a period of 5 months there were 29 separate incidents documented indicating that the resident was found displaying specific responsive behaviours. The plan of care was reviewed and under the section regarding resident #002's specific responsive behaviours, the interventions found do not set out clear directions to staff and others who provide direct care to this resident. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. (106)

5. Critical Incident System Reports submitted to the Ministry of Health and Long-Term Care indicate that resident #004 was found displaying responsive behaviours. Progress notes for resident #004 indicate that on 7 different occasions resident #004 was found displaying responsive behaviours. The plan of care for resident #004 was reviewed and the section this resident's specific behaviours contains multiple interventions. None of which sets out clear directions to staff regarding monitoring or preventions of these specific behaviours. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. (106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

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

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.

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, 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
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 2nd day of August, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MARGOT BURNS-PROUTY

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

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 2, 2013	2013_211106_0008	891,138,82, 1265,30	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 6, 7, 8, 9, 10, 2013

The following logs were reviewed as part of this critical incident inspection: Log # S-001292-12, S-001293-12, S-001294-12, S-001295-12, S-001296-12, S-001297-12, S-001298-12,S-001302-13, S-001303-12, S-001304-12, S-001265-12, S-000082-13, S-000891-12, S-000136-13, S-000137-13, S-000138-13, S-000924-12

No concurrent inspections completed during this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Housekeepers, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. One Voluntary Plan of Correction under O. Reg. 79/10, s. 53 (3) (a) has previously been issued in August 2012 during inspection #2012_051106_0015. [s. 53. (3) (a)]

2. Inspector requested and was provided a written description of the home's responsive behaviour program which consisted of the following documents, "Responsive Behaviours" policy # 09-05-01, "Responsive Episode Debriefing" policy # 09-05-02, and document named "Responsive Behaviours".

Inspector asked staff member # S-100 about the "responsive behaviour record" tool that is indicated to be used by staff in the written program. Staff member # S-100 stated that they were aware of the tool but it is not currently in use and that the Director of Care was going to do an in-service to train staff regarding the tool before it is implemented in the home.

During the entrance interview staff member # S-101 and # S-102 reported that 100% of staff have completed responsive behaviour training in the last 12 months. It was reported the training focused on the ABC Model and Person Centered Care (PCC). An "ABC Behaviour Analysis Chart" for resident #003 was reviewed and staff had filled the form out in an inappropriate manner. In column C, "Consequence (interaction (s)/response(s) to behaviour)", staff had written comments such as "thankful", "have a good day." and "See you later." Incidents where resident #003 had displayed specific responsive behaviours or staff redirecting them multiple times on a certain day were not documented on this form, the only comment regarding the day that these incidents occurred on the ABC form is "pleasant".

Residents #001, #002, #003 and #004 all display responsive behaviours in the home, the plans of care for these residents were reviewed and they do not contain all the required information that is specified in section 8 of the home's "Responsive Behaviours" policy # 09-05-01, nor have the assessment, reassessment or referral processes as stated in this policy been followed.

On May 8, 2013, during an interview with staff member #S-102 they reported that the Extendicare Responsive Behaviours Program was not fully implemented in the home and prior to February 2013 the home did not have a Revera Responsive Behaviour Program fully implemented in the home.

The licensee failed to ensure that a Responsive Behaviour Program is developed and

1. One Voluntary Plan of Correction under O. Reg. 79/10, s. 53 (3) (a) has previously

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. Two Critical Incident System (CIS) reports submitted to the Ministry of Health and Long-Term Care indicates that resident #002 was abused by resident #003.

Progress notes were reviewed for residents #002 and #003, they indicate that on three different occasions resident #002 was abused by resident #003. The licensee failed to ensure that resident #002 was protected from abuse. [s. 19. (1)]

2. A Critical Incident System report that was submitted to the Ministry of Health and Long-Term Care indicates that resident #002 was abused by resident #001. Progress notes for resident #001 indicate that on two other occasions resident #002 was abused by resident #001. The licensee failed to ensure that resident #002 was protected from abuse. [s. 19. (1)]

3. One Voluntary Plan of Correction under LTCHA, 2007, S. O. 2007, c. 8, s. 19 (1) has previously been issued in August 2012 during inspection # 012_051106_0015. [s. 19. (1)]

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. 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).

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).

Findings/Faits saillants :

1. Critical Incident System Reports submitted to the Ministry of Health and Long-Term Care indicate that resident #004 displayed specific responsive behaviours. Progress notes for resident #004 indicate that on 7 different occasions resident #004 was found displaying specific responsive behaviours. The plan of care for resident #004 was reviewed and the section regarding the resident's specific responsive behaviours contains multiple interventions. None of which sets out clear directions to staff regarding monitoring or preventions of these specific behaviours. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The progress notes for resident #002 were reviewed. During a period of 5 months there were 29 separate incidents documented indicating that the resident was found displaying specific responsive behaviours. The plan of care was reviewed and under the section regarding resident #002's specific responsive behaviours, the interventions found do not set out clear directions to staff and others who provide direct care to this resident. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. Three Critical Incident System (CIS) reports submitted to the Ministry of Health and Long-Term Care indicate that resident #001 was found displaying specific responsive behaviours. Progress notes for resident #001 indicate that on four separate occasions the resident displayed specific responsive behaviours. The plan of care for resident #001 was reviewed there were no clear directions found on how staff are to manage the resident's specific responsive behaviours. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. Over a period of 4 months, resident #003 is documented as being witnessed by staff and/or residents as displaying responsive behaviours on numerous different occasions. The plan of care for resident #003 was reviewed and no interventions directing staff how to manage the resident's specific responsive behaviours were found. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

5. The health care record for resident #009, including progress notes and plan of care were reviewed by inspector. The progress notes indicate that the resident has displayed specific responsive behaviors on 9 separate occasions during the last 9

months. The plan of care for this resident was reviewed and the section specific to these behaviours does not identify these specific behaviours, nor does it provide any directions for staff to implement when resident #009 exhibits these behaviours. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

6. The plan of care for resident #001 was reviewed, the following intervention was found, "monitor q 1/2 hour". On May 8, 2013, staff member # S-103 reported to inspector, that resident #001 is not on 1/2 hour checks. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

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. On May 7, 2013, resident #018 asked inspector, if they could go to bed. Resident #018 stated that they had been waiting for 30 minutes and had asked 4 other staff members to assist them to bed.

Inspector located a PSW who was taking a resident to the tub room and told them that resident #018 wanted to go to bed. The PSW stated that they were aware that resident #018 wanted to go to bed but, they are a 2 person transfer and would have to wait for 2 staff members to assist them. The PSW then took the resident that was with them into the tub room.

Approximately 15 minutes after resident #018 first informed the inspector they wanted to be assisted to bed a RN and a second PSW were observed to assist the resident. The licensee failed to ensure that resident #018's right to be properly sheltered, fed, clothed groomed and cared for in a manner consistent with his or her needs was fully respected and promoted. [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 to ensure that resident #018's right to be properly sheltered, fed, clothed groomed and cared for in a manner consistent with his or her needs is fully respected and promoted, specifically in regards to being assisted to bed as requested by resident #018, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. On May 10, 2013, Inspector requested to see the home's investigation into 6 incidents of alleged, suspected or witnessed abuse that were reported to the Director. Staff member # S-102 reported that they were unaware of the requirement to investigate incidents of abuse other than incidents of financial abuse. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse by anyone, that licensee the knows of, or that is reported to the licensee, is immediately investigated. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #6: 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. Three Critical Incident System (CIS) reports that were submitted to the Ministry of Health and Long-Term Care were reviewed. Although the home submitted these CIS reports, they did not immediately notify the Director of these incidents of abuse. The licensee failed to ensure that a 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 risk of harm to a resident has occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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 a 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 risk of harm to a resident has occurred or may have occurred immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 13th day of August, 2013

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