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 prévue 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 soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 19, 2019	2019_722630_0013	006354-19, 006710-19, 007386-19	Critical Incident System

Licensee/Titulaire de permis

Copper Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Copper Terrace
91 Tecumseh Road CHATHAM ON N7M 1B3

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

AMIE GIBBS-WARD (630), CASSANDRA ALEKSIC (689), HELENE DESABRAIS (615), KARIN MUSSART (145), MELANIE NORTHEY (563)

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 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28, 29 and 30, 2019.

The following Critical Incident System (CIS) intakes were completed within this inspection:

Log #006354-19 / CIS Report #1115-000013-19 related to maintenance services and

loss of essential elevator services;
Log #006710-19 / CIS Report #1115-000018-19 related to resident to resident sexual abuse;
Log #007386-19 / CIS Report #1115-000021-19 related to medication administration.

Documentation of non-compliance related to Complaint Inspection #2019_722630_0014 for Log #008162-19 and Log #010152-19 have been included within this Critical Incident System Inspection Report.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director (ED), the APANS ED Special Projects, the APANS Vice President of Best Practice and Innovation, the Director of Clinical Services (DOCS), the Associate DOCS, the Resident Assessment Instrument (RAI) Coordinator, the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), the BSO Personal Support Workers (PSW), Registered Nurses (RNs), RPNs, a RPN student, family members and residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the written staffing plan of the home, reviewed various meeting minutes, reviewed written records of program evaluations and also reviewed the APANS Compliance Action Plan.

Inspection Managers (IMs) Neil Kikuta and Kevin Bachert were also on-site during this inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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	Légende 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee has failed to ensure that for each resident demonstrating responsive behaviours the behavioural triggers for the resident were identified and actions were taken to respond to the needs of the resident, including reassessments and interventions and that the resident's responses to interventions were documented.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to an allegation of a specific type of resident to resident abuse.

A review of the home's policy titled "Responsive Behaviours Policy" effective May 2017, stated in part "To meet the needs of residents with responsive behaviours, there will be written approaches to care whether they address cognitive, physical, emotional, social, environmental factors which will include screening protocols, assessments, reassessments and the identification of individual resident triggers. Residents will be monitored and reassessed, upon admission when a plan of care will be completed and reviewed at least quarterly and when there is a change in condition."

The clinical record for one of the identified residents in the CIS report included progress notes which documented specific incidents of responsive behaviours which were directed towards other residents in the home. The clinical record also showed that this resident had been discharged from the BSO team on a specific date, which was prior to the date

of the CIS report. There was no documented evidence that the resident was reassessed to identify factors that could potentially trigger such altercations and identifying and implementing interventions.

During interviews with identified staff members they stated that they had heard that this resident had a specific type of responsive behaviours and that the resident's care plan was not reflecting the resident's current condition.

During interviews with the BSO team members they stated that they were unaware of this resident's changes in behaviours. They said they would have expected a referral so that the resident could be reassessed and interventions put in place to minimize the risks of altercations between the residents.

During an interview, the Director of Clinical Services (DOCS) stated that they were aware of this resident's responsive behaviours and two specific documented incidents involving other residents in the home. The DOCS said that the last time this resident had a responsive behaviours assessment completed was over a year ago. The DOCS said the resident should have been reassessed so that interventions could have been put in place to minimize the risks of altercations between residents.

B) A review of another identified resident's clinical record included documented incidents of a specific type of responsive behavior which were directed towards other residents and staff. This resident's clinical records and plan of care included no documented evidence that the resident was reassessed identifying factors that could potentially trigger such altercations and to show that interventions had been identified and implemented.

During interviews with the BSO team they said they were unaware that this resident had this type of behaviours during a specific time period. They said they would have expected a referral so that the resident could have been reassessed and interventions put in place to minimize the risks of altercations between the residents and staff.

During an interview, the DOCS stated that they were not aware of this resident's responsive behaviours and the resident should have been reassessed so that interventions could have been put in place to minimize the risks of altercations between the residents and staff.

The licensee has failed to ensure that behavioural triggers for these two residents were identified and actions were taken to respond to the needs of the residents related to their

responsive behaviours, including reassessments and interventions and that the residents' responses to interventions were documented. (615) [s. 53. (4) (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. 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 :

The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place a protocol, that the protocol was complied with.

Section 53 (1) of O. Reg. 79/10 states "every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: 3. Resident monitoring and internal reporting protocols."

A) The home submitted a Critical Incident System (CIS) to the MOHLTC which was related to an alleged resident to resident abuse.

Review of the home's policy titled "Responsive Behaviours Policy" effective May 2017, stated in part "All incidents of responsive behaviour (s) must be documented. Document all behaviours, resident responses, interventions and evaluations of interventions in the resident care plan. A resident incident report must be completed in Risk Management (PCC)."

The clinical record for the identified resident included a progress note which described previous incidents of a similar nature.

The Director of Clinical Services (DOCS) provided Inspector #615 with the home's incident reports documented for this identified resident which had been documented in the Risk Management part of Point Click Care (PCC). A review of these reports found they did not include the responsive behaviour incidents for all the dates documented in the progress notes.

During an interview, an identified staff member stated that all incidents related to residents' responsive behaviours should be documented in Risk Management as per the home's policy.

During an interview, the BSO team members stated that part of their task was to review the Risk Management and assessments in progress notes to learn about residents with responsive behaviours. The BSO team said that they were unaware of the incidents all the incidents for this identified resident for a specific time frame and that they would have expected to have those in Risk Management as per the home's policy.

B) A review of another identified resident's clinical record included documented incidents of a specific type of responsive behavior which was directed towards other residents and staff.

The DOCS provided Inspector #615 with the home's incident reports documented for this resident which had been documented in Risk Management. A review of these reports found they did not include the responsive behaviour incidents for all dates documented in the progress notes.

During an interview, an identified staff member stated that all incidents of responsive behaviours in residents should be documented in Risk Management as per the home's policy.

During an interview, the BSO team members stated that part of their task was to review the Risk Management and assessments in progress in PCC to learn about residents with responsive behaviours. They said that they were unaware of this resident's incidents during a specific time frame, and that they would expected to have those in Risk Management as per the home's policy.

During interviews the DOCS stated that any incidents that occurred in the home would be found in Risk Management. The DOCS added that the incidents for these two identified resident were not all in Risk Management and that they would have expected that staff would document them in Risk Management as per the home's policy so that they would be aware of those incidents.

The licensee has failed to ensure that the protocol for monitoring and internal reporting related to residents' responsive behaviours was complied with. (615) [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 to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, instituted or otherwise put in place a protocol, that the protocol is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate

actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The Long-Term Care Homes Act, 2007, Ontario Regulation 79/10 defines a, "medication incident" as "a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes, an act of omission or commission, whether or not it results in harm, injury or death to a resident".

A) The MOHLTC received Complaint Log #008162-19 in April 2019 and Complaint Log #010152-19 in May 2019 which were related to shortage of staff and the administration of medications to residents.

A review of the home's policy titled "#IIIA06A Hogan Pharmacy Partners LTD. Medication incident reporting and management" stated, in part, "Registered Facility Staff will: Report any medication incident, regardless of whether it originated from pharmacy of the facility, to a Pharmacist by telephone; Report to the resident, the resident's substitute decision-maker, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident."

A review of the electronic Medication Administration Record (eMAR) for the residents in a specific area on a specific date, showed that 18 out of 19 residents did not receive their medication at the 1100 to 1200 hours medication pass.

A review of the eMAR for the residents in another specific area for another specific date showed one identified resident did not receive specific medications at bedtime medication pass. This also showed another identified resident did not receive a specific medication at the bedtime pass.

A review of the eMAR for an identified resident showed that they did not receive a specific medication for a 21 day time period.

A review of the eMAR for another identified resident showed that they did not receive a specific medication for two specific time periods.

During interviews, the DOCS stated that medications were not administrated to these identified residents as prescribed and that the medication incident was not reported as well as a medication report not completed. The DOCS added that the home's expectation was that a medication incident report should have been completed and reported. (615)

B) The home submitted a Critical Incident System (CIS) report to the MOHLTC on a specific date with a critical incident category of "Medication incident/adverse drug reaction" related to nine identified residents for multiple dates in March 2019.

The "Hogan Pharmacy Medication Incident Reports" completed for Quarter "2" (April - June 2019) did not include this incident submitted to the MOHLTC on April 4, 2019, which identified the potential omission of medications involving nine residents.

The DOCS told Inspector #563 the reporting category for the CIS report was "Medication incident/adverse drug reaction". The DOCS stated an internal medication incident report was not completed, but verified it was a documentation and omission error.

The CIS report documented that the physician and the Nurse Practitioner were notified of the medication incidents and "no new orders" were received. The CIS report also documented that the nine residents/SDMs were not notified of the medication incidents that occurred in March 2019.

The licensee failed to ensure the medication incident involving these nine residents was documented and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. (563) [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

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

The following is further evidence to support Compliance Order (CO) #005 from Inspection #2019_508137_0004 which was served on March 11, 2019, with compliance due date of April 30, 2019.

A) Complaint Log #008162-19 was submitted to the MOHLTC in April 2019 related to shortage of staff and administration of medications to residents.

A review of the home's policy titled "Hogan Pharmacy Partners – Medication Administration, General Guidelines" stated in part "medications are administered as prescribed in accordance with good nursing principles and practices; Medications are

administered in accordance with written orders of the prescriber; Medications are administered at the time they are prepared; The individual who administers the medication dose records the administration on the resident's eMAR directly after the medication is given; At the end of each medication pass, the person administering the medications reviews the eMAR to ensure necessary doses were administered and documented; If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time; the appropriate code is entered on the eMAR along with an explanation note if appropriate."

A review of the electronic Medication Administration Record (eMAR) for the residents in a specific area for a specific date showed that 18 out of 19 residents did not receive their medication at the 1100 to 1200 hours medication pass. A review of the progress notes and clinical records for all the residents who did not received their medications did not mention the reasons of the medication omissions or follow-ups.

During interviews, staff members reviewed the April 2019 eMAR for three identified residents and they stated that on this specific date, the three residents did not receive their medications at 1100 to1200 hours as it was not documented.

During interviews, the DOCS stated that medications were not administrated to 18 out of 19 residents on this specific date. The DOCS added that the home's expectation was that medications should be administrated as prescribed. (615)

B) The home submitted a CIS report submitted to the MOHLTC on a specific date which was documented as a critical Incident category of "Medication incident/adverse drug reaction" where nine residents were not given medication. This report stated that a staff member had found medication strips disposed of in the sharps container fully intact for nine residents and that another staff member had documented the disposed medications as administered or refused.

The Copper Terrace Long Term Care Facility completed a College of Nurses (CNO) Reporting related to this incident that identified "a facility RPN reported what they felt was an unusual discovery of numerous intact medication strips that were partially sticking out of a sharps container attached to medication cart. This Nurse was able to pull out numerous strips and matched the strips to the residents' eMAR and noted that all medications documented on eMAR as given for those residents for each date. This involved nine different residents and occurred on four different dates. The consequences documented, "Risk of residents not receiving or being offered medications as prescribed

may contribute increased risks to resident in regard to the management of their treatment needs and creating reactions for not receiving medications as prescribed."

Daniels Health Canada, a full-service provider of medical, sharps and biohazardous waste disposal, picked up the sharps unit where the medication strips were discovered to complete an audit. The "Daniels Diversion Report Audit Results" with a specific date was to "to determine if any meds, specifically intact medication pouches located inside the S14 Sharps Container." The audit included evidence that two identified residents' specific medication were found in the container. All medications were documented on the eMARs for both residents as having been administered by a specific staff member. The medications were omitted from administration.

During an interview the DOCS verified that two of the identified residents were not administered specific medications as prescribed on specific dates because the medications were found in the sharps container and the eMAR were signed as administered.

The eMAR and the "Medication Admin Audit Report" were reviewed for three of the nine residents and showed that for two of the three residents' medications were documented as administered even though the medications were found disposed of in the sharps container. These medications scheduled for administration on specific dates in March 2019, were not administered as scheduled according to the directions for use specified by the prescriber; the medications were disposed of in the sharps container and never prepared and presented to the residents.

The licensee failed to ensure that medications were administered to these residents in accordance with the directions for use specified by the prescriber.

C) A clinical record review of the March 2019 eMAR in PCC for an identified resident was completed as part of the inspection related to a CIS report that was submitted to the MOHLTC in April 2019. The report stated that a staff member had documented refusals for medications that were not in fact prepared and delivered to residents. A code of "2" for "Drug Refused" was documented by this staff member for bowel medications for an identified resident.

The March 2019 Medical Directive (MD) for Bowel Protocol (BP) in PCC for day two, day three and day four did not include the documentation for the administration of specific bowel medications.

The documentation provided by the DOCS to Inspector #563 included documentation for this identified resident related to their bowel movements (BM) and there were specific time frames when the resident had been coded as not having had a BM.

During an interview the DOCS acknowledged there was no bowel protocol documented as administered in the eMAR Medical Directive (MD) for day two, three or four when the resident no BM documented in POC in March 2019.

The home's policy titled "Hogan Pharmacy Partners IIAO1 – Medication Administration, General Guidelines" stated that medications were to be administered as prescribed in accordance with good nursing principles and practices. “The home has sufficient staff and a medication distribution system to ensure safe administration of medications without necessary interruptions.” Medications were to be administered in accordance with written orders of the prescriber.

During another interview the DOCS was asked by Inspector #563 “How is it determined that bowel protocol administration is required?” and the DOCS stated the alerts usually went through in Point of Care (POC) but verified there were no alerts generated for this resident. The DOCS stated the registered staff ran the “Alert Listing Report” on the night shift and they prepared a bowel list for the day shift. Inspector #563 and the DOCS reviewed the POC documentation and eMARs for this resident and the DOCS verified this resident did not receive the bowel medications that they should have received. The DOCS said the administration of bowel protocol was omitted in March 2019 for this resident when bowel medications were required as needed.

The licensee failed to ensure that bowel medications were administered to this resident in accordance with the directions for use specified by the prescriber. (563) [s. 131. (2)]

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 21st day of June, 2019

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMIE GIBBS-WARD (630), CASSANDRA ALEKSIC (689), HELENE DESABRAIS (615), KARIN MUSSART (145), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2019_722630_0013
Log No. / No de registre :	006354-19, 006710-19, 007386-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 19, 2019
Licensee / Titulaire de permis :	Copper Terrace Limited 284 Central Avenue, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	Copper Terrace 91 Tecumseh Road, CHATHAM, ON, N7M-1B3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Scott Hebert

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

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

To Copper Terrace Limited, you are hereby required to comply with the following order (s) by the date(s) set out below:

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

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

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. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(a) the behavioural triggers for the resident are identified, where possible;

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 53. (4).

Specifically the licensee shall ensure:

a) Any resident in the home demonstrating responsive behaviours that pose a risk to other residents in the home is referred to the home's Behavioural Support Ontario (BSO) Team as per the home's policies and protocols.

b) Any resident demonstrating responsive behaviours that pose a risk to other residents in the home is reassessed by the interdisciplinary team. This assessment must include the identification of behavioural triggers and interventions for the resident. The behavioural triggers and interventions must be documented in the resident's plan of care.

c) An identified resident's responsive behaviours are reassessed by the interdisciplinary team. This assessment must include the identification of behavioural triggers and interventions for this resident's responsive behaviours. The behavioural triggers and interventions must be documented in the resident's plan of care.

d) The interdisciplinary team will consistently implement the responsive behaviour plan of care for an identified resident, and any other resident demonstrating responsive behaviours, and document the resident's responses to the interventions.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours the behavioural triggers for the resident were identified and actions were taken to respond to the needs of the resident, including reassessments and interventions and that the resident's responses to interventions were documented.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to an allegation of a specific type of resident to resident abuse.

A review of the home's policy titled "Responsive Behaviours Policy" effective

May 2017, stated in part "To meet the needs of residents with responsive behaviours, there will be written approaches to care whether they address cognitive, physical, emotional, social, environmental factors which will include screening protocols, assessments, reassessments and the identification of individual resident triggers. Residents will be monitored and reassessed, upon admission when a plan of care will be completed and reviewed at least quarterly and when there is a change in condition."

The clinical record for one of the identified residents in the CIS report included progress notes which documented specific incidents of responsive behaviours which were directed towards other residents in the home. The clinical record also showed that this resident had been discharged from the BSO team on a specific date, which was prior to the date of the CIS report. There was no documented evidence that the resident was reassessed to identify factors that could potentially trigger such altercations and identifying and implementing interventions.

During interviews with identified staff members they stated that they had heard that this resident had a specific type of responsive behaviours and that the resident's care plan was not reflecting the resident's current condition.

During interviews with the BSO team members they stated that they were unaware of this resident's changes in behaviours. They said they would have expected a referral so that the resident could be reassessed and interventions put in place to minimize the risks of altercations between the residents.

During an interview, the Director of Clinical Services (DOCS) stated that they were aware of this resident's responsive behaviours and two specific documented incidents involving other residents in the home. The DOCS said that the last time this resident had a responsive behaviours assessment completed was over a year ago. The DOCS said the resident should have been reassessed so that interventions could have been put in place to minimize the risks of altercations between residents.

B) A review of another identified resident's clinical record included documented incidents of a specific type of responsive behavior which were directed towards other residents and staff. This resident's clinical records and plan of care

included no documented evidence that the resident was reassessed identifying factors that could potentially trigger such altercations and to show that interventions had been identified and implemented.

During interviews with the BSO team they said they were unaware that this resident had this type of behaviours during a specific time period. They said they would have expected a referral so that the resident could have been reassessed and interventions put in place to minimize the risks of altercations between the residents and staff.

During an interview, the DOCS stated that they were not aware of this resident's responsive behaviours and the resident should have been reassessed so that interventions could have been put in place to minimize the risks of altercations between the residents and staff.

The licensee has failed to ensure that behavioural triggers for these two residents were identified and actions were taken to respond to the needs of the residents related to their responsive behaviours, including reassessments and interventions and that the residents' responses to interventions were documented. (615) [s. 53. (4) (c)]

The severity of this issue was determined to be a level two as there was minimal harm. The scope of the issue was a level two as it was a pattern that affected two out of three residents. The home had a level three history as they had on-going noncompliance with this section of O. Reg.79/10 that included:
- Written Notification (WN) and Compliance Order (CO) issued June 16, 2017 (2017_262630_0013) which was complied April 12, 2018. (615)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amie Gibbs-Ward

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