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 le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 24, 2017;	2016_264609_0029 (A1)	030646-16	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD SUDBURY ON P3A 5K4

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

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CHAD CAMPS (609) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Two week extension on the compliance due dates for both orders.

Issued on this 24 day of February 2017 (A1)

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

Original report signed by the inspector.

Ontario

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CHAD CAMPS (609) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 14-18 and 21-25, 2016.

Additional logs inspected during this RQI included:

Two Critical Incidents the home submitted to the Director related to resident falls;

Eight Critical Incidents the home submitted to the Director related to resident to resident abuse;

One Critical Incident the home submitted to the Director related to family to resident abuse;

Three Complaints submitted to the Director related to the care of residents; and

Three Critical Incidents submitted to the Director related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Senior Administrator, Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Office Manager, Food Services Manager (FSM), Support Services Manager (SSM), Food Services Supervisor (FSS), Schedulers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs),

family members and residents.

The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, human resource files, internal investigations, and numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Skin and Wound Care

Trust Accounts

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

11 WN(s)
4 VPC(s)
2 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	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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Three Critical Incident (CI) reports were submitted to the Director related to the physically responsive behaviours of resident #015. In each of the three CI reports, resident #015 had displayed physically responsive behaviours towards residents #020, #021 and #022, all of which resulted in altered skin integrity to the residents.

Inspector #638 reviewed the health care records for resident #020, #021 and #022, which failed to document follow up assessments, wound monitoring, treatments or any identification within the care plan indicating any altered skin integrity issues for the three residents.

The home's policy titled "Skin Tears – 03-03" current version June 2010, indicated that registered staff would initiate a "Wound Care Record" in order to document the location and category of the skin tear as well as the treatment and progression of healing. The policy indicated that the registered staff were required to include

progress notes to identify the cause and initial assessment, update the care plan to document the wound, required treatments and interventions as well as create a treatment administration record to identify the completion and progress of the treatments.

During an interview with Inspector #609 on January 24, 2017, the Administrator provided a copy of the home's initial skin and wound assessment titled the "Bates-Jensen Wound Assessment Tool" last updated September 2016 which was to be completed by registered staff when a resident was identified as having altered skin integrity.

During an interview with Inspector #638, RPN #103 explained that all residents who sustained new altered skin integrity would have had a “Wound Care Record” initiated, progress notes to identify the cause and assessment of the altered skin integrity. The residents' plans of care would have been updated to document the presence of the altered skin integrity including treatment and interventions as well as create a treatment administration record to document the completion of the required treatments.

During an interview with Inspector #638, ADOC #106 verified that the three residents identified as having altered skin integrity had not received a skin assessment by a member of the registered nursing staff, using the clinically appropriate "Bates-Jensen Wound Assessment tool". [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that any resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered staff, if clinically indicated.

During stage one of the inspection, during a record review resident #001 was identified as having new altered skin integrity.

Inspector #612 reviewed resident #001’s health care records and noted that a “Skin- Weekly Wound Assessment- for New Wound” was completed on a particular day, which identified that the resident had altered skin integrity.

The Inspector reviewed the resident’s progress notes and assessments which failed to document any weekly reassessments of the wound. The Inspector reviewed the electronic treatment record (eTAR) and noted that the wound care for

the identified altered skin integrity was discontinued; however, was unable to find any corresponding progress notes or assessments.

The Inspector reviewed the home's policy titled, "Pressure Ulcers- 03-07" current version June 2010, which indicated that upon report of skin breakdown, registered staff were to assess the area and follow the treatment protocol for pressure ulcers. Following the completion of wound care treatments, registered staff were to document the completion of treatment. Weekly, the wound would be reassessed to evaluate the effectiveness of the treatment; this reassessment and evaluation were then documented in the resident's health care record. The wound care record was used to document the status of the wound. Progress notes were used to document the progression of wound healing, resident response to treatment, assessments completed and any other care related to interventions associated with the wound such as referrals to specialists.

During an interview with Inspector #609 on January 24, 2017, the Administrator provided a copy of the home's weekly skin and wound assessment titled the "Impaired Skin Integrity Assessment- Weekly Impaired Skin Integrity Assessment Version 2" last updated July 2016 which was to be completed by registered staff on a weekly basis when a resident was identified has having altered skin integrity.

During an interview with RN #104 and ADOC #106 on November 18, 2016, they stated that when a resident exhibited altered skin integrity, weekly wound assessments were to be completed under the resident's assessments. RN #104 and ADOC #106 stated that if the weekly assessment was not listed there then it had not been completed. [s. 50. (2) (b) (iv)]

3. During stage one of the inspection, during a record review resident #006 was identified as having new altered skin integrity.

a) Inspector #612 reviewed resident #006's health care record and noted that the resident was identified on a particular day as having altered skin integrity, which was identified as being healed approximately four weeks later. The Inspector was unable to locate any weekly wound assessments.

b) The inspector identified through a new wound assessment that resident #006 had altered skin integrity. The Inspector reviewed the eTAR and noted that the home's wound care protocol was initiated on a particular day for the altered skin integrity, which was discontinued two months later. The Inspector reviewed the

eTAR, the resident's assessments and the resident's progress notes which failed to document a weekly wound assessment which corresponded to the eTAR for seven of the assessment weeks. [s. 50. (2) (b) (iv)]

4. During stage one of the inspection, during a record review, resident #011 was identified as having altered skin integrity.

Inspector #612 reviewed resident #011's health care records and noted that the resident was identified as having altered skin integrity on a particular day which had healed two months later. The Inspector reviewed the resident's eTAR which identified the dates that the resident was required to have a weekly wound assessment completed. The Inspector was unable to locate an assessment for four of the required weekly wound assessments. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: 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 :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating physical and verbal responsive behaviours.

A complaint was submitted to the Director related to resident #030 demonstrating physically and verbally responsive behaviours towards residents within the home. The complaint further alleged that resident #030 had caused physical harm to resident #031 due to their responsive behaviours.

Inspector #638 conducted a review of the progress notes for resident #030 which indicated that the resident had multiple episodes of verbally and physically responsive behaviours towards staff and residents within the home. In a review of the behaviour mapping document, resident #030 had demonstrated physically responsive behaviours on four of the seven days or 57 per cent of the days during the assessment period which included five incidents of verbal and physical responsive behaviours directed towards residents and staff.

A review of the Interdisciplinary Team Care Conference indicated that resident #030 had exhibited multiple responsive behaviours, including resistance to care as well as exhibited physically responsive behaviours towards staff and other residents. The Inspector reviewed resident #030's plan of care which failed to identify any interventions that were developed or implemented to respond to the resident's responsive behaviours.

In an interview with Inspector #638, PSW #115 stated that resident #030 had displayed multiple episodes of verbally responsive behaviours towards staff and residents. The PSW then stated that the resident had two specific triggers to responsive behaviours. PSW #115 further stated that they were to refer to the "PIECES of my PERSONHOOD" document for resident #030's preferences, however, this did not provide any interventions related to the resident's responsive behaviours that could have been implemented at times of escalation.

The Inspector conducted an interview with RPN #103, which indicated that resident #030 was known for being verbally responsive, however, there was no indication of any interventions for resident #030's responsive behaviours in order to manage their behaviours.

In an interview with the home's BSO RPN #112, it was determined that resident #030 had displayed physically responsive behaviours towards staff during care giving periods as well as residents in the home and that there should have been interventions implemented in order to manage the resident's responsive behaviours.

Inspector #543 reviewed the home's policy titled "Responsive Behaviours- 09-05-01" current version September 2010, which stated that specific interventions related to behaviours would be implemented and that staff were required to be familiar with the resident's plan of care.

During a review of resident #030's care plan with Inspector #638, ADOC #106 was unable to locate any focus on responsive behaviours, including; triggers, patterns or interventions developed or implemented to respond to resident #030's responsive behaviours. ADOC #106 stated that interventions were to be developed for resident #030 who had displayed responsive behaviours so staff would be able to implement appropriate interventions to safely respond and manage their responsive behaviours. [s. 53. (4) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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 has failed to ensure that the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care were documented.

A CI report was submitted to the Director in February 2016 which outlined that resident #018 fell on on a particular day, which resulted in the resident being taken to hospital with a significant change in their condition.

Inspector #609 reviewed the health care records for resident #018 and found that on a particular day, the resident was agitated, wandering and was verbally and physically responsive. Approximately a few hours later, the resident was found on the floor, complaining of pain. The resident was then transferred to hospital where they were diagnosed with an injury.

A review of resident #018's plan of care found that a specified and timed intervention for safety was to be done during periods where the risk of falls was increased.

During an interview with ADOC #130 on November 25, 2016, they verified that when resident #018 was verbally and physically responsive and wandering they were at an increased risk of falls and that the specified and timed intervention was to be done.

During an interview with PSW #131 on November 25, 2016, they verified that they were present and working an the day resident #018 became injured and did perform the specified and timed intervention.

A review of the health care records for resident #018 found no documentation that the specified and timed intervention was completed on the particular day or any other day since the resident was admitted to the home.

During an interview with the DOC and Administrator on November 25, 2016, they stated "no" when asked if documentation was completed for the specified and timed intervention for resident #018 on the day prior to the resident's fall and subsequent transfer to hospital. [s. 6. (9) 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 the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the organized program of personal support services for the home met the assessed needs of the residents.

A complaint was submitted to the Director in October 2016 which alleged that the home was understaffed and resulted in the assessed care needs of residents not being met.

a) Inspector #609 interviewed the SDM for resident #023 who stated that during the evening shift on a particular day, the home was critically short of PSWs and as a result none of the residents on the fourth floor received their scheduled bath or shower.

A review of the home's schedule for a specified time frame, found that on 17 of the 82 days or 18 per cent, the home was short three or more PSWs on a single shift, which included the day of the complaint by the SDM for resident #023.

A review of the daily assignment document for fourth floor indicated that residents #014, #035, #036, #037, #038, #039 and #040 and #041 were to have received a bath or shower during the evening shift on the particular day.

A review of the Point of Care (POC) documentation for bathing for the eight identified residents found the care was inputted as not applicable or was left blank.

During an interview with PSW #119 on November 23, 2016, they indicated that when a floor of the home was short three or more PSWs, scheduled baths and showers were not performed and that not applicable was inputted into the resident's health care records.

During an interview with PSW #120 on November 23, 2016, they verified they were present and working the fourth floor evening shift on the particular day. PSW #120 further verified that the floor was operating short three PSWs and as a result none of the scheduled baths or showers were completed.

A review of the home's policy titled "Activities of Daily Living, Bathing- RESI-05-07-23" revised date August 2005, indicated that all residents would be offered a minimum of two baths per week.

During an interview with the Administrator on November 23, 2016, they stated that residents should have received their scheduled baths and showers regardless of the staffing level in the home and that this did not occur for the eight residents identified on the particular day when the fourth floor was short three PSWs on the evening shift.

b) When asked on November 23, 2016, if there was a process for tracking and making up missed baths and showers PSW #119 and #120 were unaware of any process to ensure they were made up.

During an interview with RPN #111 on November 24, 2016, they indicated that if a resident did not receive a scheduled bath or shower it was expected that the PSW assigned to the resident would alert the RPN in order document the missed bath or shower in the resident's health care records through a progress note.

A review of the health care records for all eight identified residents found no progress notes by any staff that indicated the residents had missed their evening bath or shower on the particular day.

A review of the POC documentation for the eight identified residents found seven of the eight residents received their next bath or shower on their next scheduled bathing day which resulted in a one week gap between a bath or shower. No documentation was found to support any attempt was made by the home to make up the missed baths and showers.

During an interview with the DOC on November 24, 2016, the DOC was unable to provide any process in the home to track missed baths and showers to ensure that they were made up by staff.

c) During an interview with resident #041 they indicated that on a particular day, after ringing the call bell for assistance to bed, staff informed the resident that the fourth floor evening shift was short three PSWs. Staff further informed the resident that they would have to wait for assistance and turned off the call bell. Resident #041 also indicated that by this time they had been in their wheelchair for over 14 hours.

Resident #041 explained that after their call for assistance was denied by staff they did not ask for any other help, until after 17 hours in their wheelchair, RN #114 happened to walk by the resident's door, saw that the resident was not yet assisted and proceeded to assist the resident into bed.

A review of the plan of care for resident #041 directed staff to assist the resident to bed hours before they were eventually assisted to bed.

A review of the home's schedule on the particular day found that the evening shift on fourth floor was short three PSWs.

During an interview with RN #114 on November 22, 2016, they verified that they were present and working the evening of the particular day, that the fourth floor was working short three PSWs and happened to walk by resident #041's open door, saw that the resident was not yet assisted and assisted the resident into bed.

A review of resident #041's health care records found that on a particular day the resident complained to the dayshift RPN that they waited three hours after they requested assistance to go to bed.

A review of the home's policy titled "Resident Safety/Emergency Procedures, Nurse Call System- RESI-08-02-01" implementation date December 2002 directed staff to respond to calls in a rapid manner.

During an interview with the DOC on November 23, 2016, they stated that the needs of residents were to be met regardless of the staffing level of the home and this did not occur on the particular day's evening shift when resident #041 waited three hours for assistance to bed. [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 there is an organized program of personal support services for the home to meet the assessed needs of the residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

On November 16, 2016, Inspector #609 observed bed rails engaged on the beds of resident #001 and #005.

On November 14, 2016, Inspector #612 observed bed rails engaged on the bed of resident #008.

A review of the home's policy titled "Bed Entrapment and Proper Use of Bedrail Devices- 08-10-01" version April 2011 indicated that staff were to conduct an initial needs assessment to determine the most appropriate bed system for each resident and reassess the resident when needs changed or there was a significant change in their condition.

During an interview with ADOC #106 on November 18, 2016, they indicated that the home utilized the "Bed Rail Decision Tree" document dated March 2011 for the assessment and implementation of bed rails in the home.

Inspector #609 interviewed the DOC and ADOC #106 on November 17, 2016, who both verified that the "Clinical Guidance For the Assessment and Implementation of

Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" April 2003 document guided in the assessment and use of bed rails in the home.

A review of the "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" April 2003 found that any decision regarding bed rail use or removal from use should be made within the framework of an individual patient assessment that included medical diagnosis, conditions, symptoms, and/or behavioral symptoms, sleep habits, medication, acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, cognition, communication, mobility (in and out of bed) and risk of falling.

A review of the home's "Bed Rail Decision Tree" document dated March 2011 found the decision tree did not address medical diagnosis, conditions, symptoms, and/or behavioral symptoms, sleep habits, medication, acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication, or mobility out of bed.

During the same interview with ADOC #106 on November 18, 2016, they acknowledged that the "Bed Rail Decision Tree" document was not an individualized patient assessment that addressed all the required components for bed rail use or removal as specified in the "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" document. [s. 15. (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 where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and ensure that the policy was complied with.

Three CI reports were submitted to the Director related to the physically responsive behaviours of resident #015. In each of the CI reports, resident #015 had displayed physically responsive behaviours towards other residents in the home, which resulted in injury to the residents.

Inspector #638, reviewed the progress notes for resident #015 and found that resident #015 had demonstrated additional physically responsive behaviours, one of which was directed towards resident #025 on a particular day, which resulted in resident #025 in having altered skin integrity.

During an interview with RPN #110, they stated that they had responded to the altercation which occurred between resident #015 and #025. The RPN then stated that resident #025 had sustained altered skin integrity as a result of resident #015's physically responsive behaviours. RPN #110 did not report the incident to the RN

or the on called designate.

A review of the home's policy titled "Mandatory and Critical Incident Reports– RC-11-01-06" last revised April 2016, indicated that each incident of abuse of a resident by anyone was to be reported to the DOC or Designate.

During on an interview with the DOC, they stated that any witnessed incidents of abuse were to be immediately reported to the RN or the on call designate in order to create a CI report as necessary and that this did not occur. [s. 20. (1)]

2. A CI report was submitted to the Director in August 2016 related to alleged staff to resident abuse.

According to the CI report, PSW #122 had reported that they witnessed another employee pull down resident #016's pants and make an inappropriate comment about their genitals.

Inspector #543 reviewed the home's internal investigation notes, which indicated that PSW #122 stated that another PSW made inappropriate comments about resident #016's genitals, while a third PSW also made an inappropriate comment at that time. PSW #122 stated they felt it was disrespectful towards resident #016.

Inspector #543 reviewed the home's internal investigation documentation related to the incident that occurred which identified that the behaviour of PSW #123 and #124 involved in the incident was in violation of the home abuse policy, the resident's rights and the home's employee standard of conduct.

The Inspector reviewed the home's Zero Tolerance of Abuse and Neglect Policy (RC-02-01-01), which defined verbal abuse as any form of verbal communication of a belittling or degrading nature which diminished a resident's sense of well-being, dignity or self-worth, that was made by anyone other than a resident. The policy 's definition of emotional abuse, included but was not limited to any insulting, intimidating or humiliating gestures, actions, behaviours or remarks, that were performed by anyone other than a resident. This policy indicated that the home had a zero tolerance of abuse and that any form of abuse by any person interacting with residents, whether through deliberated acts or negligence, would not be tolerated.

Inspector #543 spoke with the DOC who stated that the behaviour of PSW #123

and #124 was in violation of the resident's rights as well as the home's employee standards of conduct and did not comply with the home's abuse policy. [s. 20. (1)]

3. A CI report was submitted to the Director in October 2016 related to alleged staff to resident verbal abuse.

According to the CI report, RPN #129 was overheard arguing with resident #017 by RPN #127 and PSW #128. RPN #129 was heard speaking to the resident in an inappropriate manner using profanity.

Inspector #543 reviewed this resident's health care records, which indicated a verbal altercation had occurred between resident #017 and RPN #129. The progress notes described that RPN #129 was verbally inappropriate towards the resident.

The inspector reviewed the home's internal investigation documentation which indicated that resident #017 was heard yelling and cursing loudly. The documentation stated that RPN #129 was assisting the resident with personal care, when RPN #127 and PSW #128 heard them yell and use profanity at the resident. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids were labelled within 48 hours of admission and of acquiring, in the case of new items.

On November 16, 2016, Inspector #612 observed a used, unlabeled denture cup in resident #026's shared room.

On November 14, 2016, Inspector #609 observed two used, unlabeled denture cups in resident #027's shared room, used unlabeled deodorant in resident #028's shared room as well as another used unlabeled deodorant in resident #029's shared room.

During an interview with RPN #111 on November 14, 2016, they verified that all personal items were to be labeled for all residents.

During an interview with ADOC #106 on November 21, 2016, they indicated that all personal items were to have been labeled within 48 hours of admission and of acquiring in the case of new items and this had not occurred with the personal items in the shared rooms of residents' #026, #027, #028 and #029. [s. 37. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the dining and snack service included a review of the meal and snack times by the Residents' Council.

On November 23, 2016, Inspector #609 observed the breakfast meal service on a resident home area which began at 0900 hours. At 0945 hours a second meal service began for the remaining residents on the same resident area, which ended at approximately 1045 hours.

During an interview with PSW #116 they verified that there were two meal services on this specific home area related to the amount of residents on the unit. PSW #116 further verified that the first breakfast meal service began at 0900 hours and the second meal service for the remaining residents typically began at 0945 hours.

During an interview with resident #033 on a particular day, they indicated that a sub-committee called the Resident Food Committee reviewed meal and snack times on behalf of the Resident's Council. Resident #033 directed the Inspector to speak with resident #032.

A review of the Resident Food Committee meeting minutes dated September 12, 2016, indicated that breakfast meal service started at 0900 hours, the lunch meal service at 1245 hours and the dinner meal service at 1730 hours. There was no indication in the Resident Food Committee meeting minutes of two different start times for meals depending on the unit.

During an interview with resident #032 on November 23, 2016, they verified they had approved the meal times at the September 2016 meeting. Resident #032 was unaware of the two meal times for residents on the identified resident home area.

During an interview with the FSM on November 23, 2016, a review of the meal times was conducted who verified that the home had two different meal times depending on which floor they were located on. A review of the approved meal times the home received from the Residents Food Committee was conducted with the FSM who verified that the committee on September 12, 2016, had not reviewed nor approved the second seating for meals with its differing meal times. [s. 73. (1) 2.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an injury in respect of which a person was taken to hospital.

A CI report was submitted to the Director in November 2016 related to a fall resident #019 sustained on a particular day, where they were subsequently transferred to the hospital for reassessment.

Inspector #543 reviewed resident #019's health care records and found that the home's physician had reviewed the resident's test results after returning to the home and noted that they had sustained an injury.

During an interview with the DOC, they verified that they were made aware of resident #019's injury but did not report the resident's significant change in health status through the CI system until eight days later. [s. 107. (3) 4.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(c) that the local medical officer of health is invited to the meetings; O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the local Medical Officer of Health was invited to the home's Infection Prevention and Control (IPAC) team meetings.

During an interview with ADOC #106 on November 21, 2016, they verified that the home held quarterly IPAC team meetings.

A review of the correspondence between the Medical Officer of Health's office and the home found that a voice mail invitation and one email invitation was left with the Medical Officer of Health's office for two of the four quarterly IPAC meetings held in the home for the 2016 year.

During an interview with the DOC on November 23, 2016, they indicated that the Medical Officer of Health was to have been invited to all quarterly IPAC meetings and that this did not occur for two of the four or 50 per cent of the meetings. [s. 229. (2) (c)]

2. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

On a particular day at an identified time, Inspector #609 observed PSW #109 and two other PSWs transfer resident #024. None of the PSWs involved utilized

Personal Protective Equipment (PPE) when performing the transfer. After resident #024 was transferred, two of the PSWs involved did not wash their hands and went on to other performed tasks (making a bed and folding clothes) for the resident's roommates.

A review of the signage outside of resident #024's room indicated that the resident had specified interventions staff were to have used when caring for the resident.

A review of the plan of care for resident #024 indicated that the resident had specific outlined interventions staff were to have used when caring for the resident.

During an interview on November 16, 2016, PSW #109 stated that they were not required to use the specific outlined interventions with resident #024.

During an interview with ADOC #106 on November 16, 2016, they indicated that staff were to have adhered to the interventions stipulated in resident #024's plan of care, and that the three PSWs caring for resident #024 on the particular day, did not follow the specific, outlined interventions. [s. 229. (4)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (5) Every licensee shall establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money, which must include,
(a) a system to record the written authorizations required under subsection (8); and O. Reg. 79/10, s. 241 (5).
(b) the hours when the resident, or the person acting on behalf of the resident, can make deposits to or withdrawals from the resident's funds in a trust account and make withdrawals from the petty cash trust money. O. Reg. 79/10, s. 241 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy and procedures for the management of resident trust accounts and the petty cash trust money included the hours when the resident, or the person acting on behalf of the resident, could make deposits to or withdrawals from the resident's funds in a trust account and make withdrawals from the petty cash trust money.

Inspector #609 interviewed resident #005 and #007 on two particular days who both stated that they could not withdraw money from their trust accounts when they needed as the office was open for withdrawals for three days during the work week.

A review of the home's policy titled "Trust Fund Accounts" dated November 2010 indicated that funds could be withdrawn on Tuesdays, Wednesdays and Thursdays between 0800 and 1700 hours.

During an interview with the Office Manager on November 18, 2016, they verified that the office was open Tuesday, Wednesday and Thursday each week for residents to withdraw their money. The Office Manager also stated that it was the policy of home that if there were exceptional circumstances whereby the resident required funds outside of the specified times (i.e. over the weekend) the home would accommodate their requests.

A further review of the home's policy titled "Trust Fund Accounts" dated November 2010 found no mention that residents could access their trust accounts outside of the specified times if they needed to.

During the same interview with the Office Manager on November 18, 2016, they verified that all residents and persons acting on behalf of a resident were provided the "Trust Fund Accounts" policy and that there was no way for the residents and persons acting on behalf of a resident could know by reading the policy that funds could have been accessed outside of the specified times if exceptional circumstances arose. [s. 241. (5)]

Issued on this 24 day of February 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : CHAD CAMPS (609) - (A1)

Inspection No. / No de l'inspection : 2016_264609_0029 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 030646-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 24, 2017;(A1)

Licensee / Titulaire de permis :
EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD :
EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD, SUDBURY, ON,
P3A-5K4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Laura Halloran

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 EXTENDICARE (CANADA) 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. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall:

a) Ensure that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

b) Ensure that any resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Three Critical Incident (CI) reports were submitted to the Director related to the physically responsive behaviours of resident #015. In each of the three CI reports, resident #015 had displayed physically responsive behaviours towards residents #020, #021 and #022, all of which resulted in altered skin integrity to the residents.

Inspector #638 reviewed the health care records for resident #020, #021 and #022, which failed to document follow up assessments, wound monitoring, treatments or any identification within the care plan indicating any altered skin integrity issues for the three residents.

The home's policy titled "Skin Tears – 03-03" current version June 2010, indicated that registered staff would initiate a "Wound Care Record" in order to document the location and category of the skin tear as well as the treatment and progression of healing. The policy indicated that the registered staff were required to include progress notes to identify the cause and initial assessment, update the care plan to document the wound, required treatments and interventions as well as create a treatment administration record to identify the completion and progress of the treatments.

During an interview with Inspector #609 on January 24, 2017, the Administrator provided a copy of the home's initial skin and wound assessment titled the "Bates-Jensen Wound Assessment Tool" last updated September 2016 which was to be completed by registered staff when a resident was identified as having altered skin integrity.

During an interview with Inspector #638, Registered Practical Nurse (RPN) #103 explained that all residents who sustained new altered skin integrity would have had a "Wound Care Record" initiated, progress notes to identify the cause and assessment of the altered skin integrity. The residents' plans of care would have been updated to document the presence of the altered skin integrity including treatment and interventions as well as create a treatment administration record to document the completion of the required treatments.

During an interview with Inspector #638, Assistant Director of Care (ADOC) #106 verified that the three residents identified as having altered skin integrity had not received a skin assessment by a member of the registered nursing staff, using the clinically appropriate "Bates-Jensen Wound Assessment tool". (609)

2. The licensee has failed to ensure that any resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered staff, if clinically indicated.

During stage one of the inspection, during a record review, resident #011 was identified as having altered skin integrity.

Inspector #612 reviewed resident #011's health care records and noted that the resident was identified as having altered skin integrity on a particular day which had healed two months later. The Inspector reviewed the resident's eTAR which identified the dates that the resident was required to have a weekly wound assessment completed. The Inspector was unable to locate an assessment for four of the required weekly wound assessments. (612)

3. During stage one of the inspection, during a record review resident #006 was identified as having new altered skin integrity.

a) Inspector #612 reviewed resident #006's health care record and noted that the resident was identified on a particular day as having altered skin integrity, which was identified as being healed approximately four weeks later. The Inspector was unable to locate any weekly wound assessments.

b) The inspector identified through a new wound assessment that resident #006 had altered skin integrity. The Inspector reviewed the eTAR and noted that the home's wound care protocol was initiated on a particular day for the altered skin integrity, which was discontinued two months later. The Inspector reviewed the eTAR, the resident's assessments and the resident's progress notes which failed to document a weekly wound assessment which corresponded to the eTAR for seven of the assessment weeks. (612)

4. During stage one of the inspection, during a record review resident #001 was identified as having new altered skin integrity.

Inspector #612 reviewed resident #001's health care records and noted that a "Skin-Weekly Wound Assessment- for New Wound" was completed on a particular day, which identified that the resident had altered skin integrity.

The Inspector reviewed the resident's progress notes and assessments which failed to document any weekly reassessments of the wound. The Inspector reviewed the electronic treatment record (eTAR) and noted that the wound care for the identified altered skin integrity was discontinued; however, was unable to find any corresponding progress notes or assessments.

The Inspector reviewed the home's policy titled, "Pressure Ulcers- 03-07" current version June 2010, which indicated that upon report of skin breakdown, registered staff were to assess the area and follow the treatment protocol for pressure ulcers. Following the completion of wound care treatments, registered staff were to document the completion of treatment. Weekly, the wound would be reassessed to evaluate the effectiveness of the treatment; this reassessment and evaluation were

then documented in the resident's health care record. The wound care record was used to document the status of the wound. Progress notes were used to document the progression of wound healing, resident response to treatment, assessments completed and any other care related to interventions associated with the wound such as referrals to specialists.

During an interview with Inspector #609 on January 24, 2017, the Administrator provided a copy of the home's weekly skin and wound assessment titled the "Impaired Skin Integrity Assessment- Weekly Impaired Skin Integrity Assessment Version 2" last updated July 2016 which was to be completed by registered staff on a weekly basis when a resident was identified has having altered skin integrity.

During an interview with Registered Nurse (RN) #104 and ADOC #106 on November 18, 2016, they stated that when a resident exhibited altered skin integrity, weekly wound assessments were to be completed under the resident's assessments. RN #104 and ADOC #106 stated that if the weekly assessment was not listed there then it had not been completed.

The scope of this issue was determined to have been a pattern of initial skin assessments as well as weekly skin reassessments not performed by the home's registered nursing staff. There was a previous Written Notification (WN) issued related to this provision during inspection #2015_282543_0014 on June 8, 2015. The severity was determined to have been potential for actual harm to the health, safety and well-being of residents not provided with timely, completed and documented initial skin assessments and weekly skin reassessments. (612)

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

Mar 23, 2017(A1)

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 : 002

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 shall:

a) Specifically ensure that strategies and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of residents #030's responsive behaviours.

b) Ensure that the procedures and interventions developed and implemented to
manage residents' responsive behaviours are clearly documented and that staff
have access and are aware of them.

Grounds / Motifs :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating physical and verbal responsive behaviours.

A complaint was submitted to the Director related to resident #030 demonstrating physically and verbally responsive behaviours towards residents within the home. The complaint further alleged that resident #030 had caused physical harm to

resident #031 due to their responsive behaviours.

Inspector #638 conducted a review of the progress notes for resident #030 which indicated that the resident had multiple episodes of verbally and physically responsive behaviours towards staff and residents within the home. In a review of the behaviour mapping document, resident #030 had demonstrated physically responsive behaviours on four of the seven days or 57 per cent of the days during the assessment period which included five incidents of verbal and physical responsive behaviours directed towards residents and staff.

A review of the Interdisciplinary Team Care Conference indicated that resident #030 had exhibited multiple responsive behaviours, including resistance to care as well as exhibited physically responsive behaviours towards staff and other residents. The Inspector reviewed resident #030's plan of care which failed to identify any interventions that were developed or implemented to respond to the resident's responsive behaviours.

In an interview with Inspector #638, Personal Support Worker (PSW) #115 stated that resident #030 had displayed multiple episodes of verbally responsive behaviours towards staff and residents. The PSW then stated that the resident had two specific triggers to responsive behaviours. PSW #115 further stated that they were to refer to the "PIECES of my PERSONHOOD" document for resident #030's preferences, however, this did not provide any interventions related to the resident's responsive behaviours that could have been implemented at times of escalation.

The Inspector conducted an interview with Registered Practical Nurse (RPN) #103, which indicated that resident #030 was known for being verbally responsive, however, there was no indication of any interventions for resident #030's responsive behaviours in order to manage their behaviours.

In an interview with the home's Behavioural Supports Ontario (BSO) RPN #112, it was determined that resident #030 had displayed physically responsive behaviours towards staff during care giving periods as well as residents in the home and that there should have been interventions implemented in order to manage the resident's responsive behaviours.

Inspector #543 reviewed the home's policy titled "Responsive Behaviours- 09-05-01" current version September 2010, which stated that specific interventions related to

behaviours would be implemented and that staff were required to be familiar with the resident's plan of care.

During a review of resident #030's care plan with Inspector #638, Assistant Director of Care (ADOC) #106 was unable to locate any focus on responsive behaviours, including; triggers, patterns or interventions developed or implemented to respond to resident #030's responsive behaviours. ADOC #106 stated that interventions were to be developed for resident #030 who had displayed responsive behaviours so staff would be able to implement appropriate interventions to safely respond and manage their responsive behaviours.

The scope of this issue was determined to have been a pattern of procedures and interventions not developed or implemented to assist residents and staff who were at risk of harm or who were harmed as a result of residents' behaviours. There was no previous non-compliance related to this provision. The severity was determined to have been actual harm to the health, safety and well-being of residents affected by the responsive behaviours of resident #030 and any other residents demonstrating responsive behaviours not managed. (609)

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

Mar 23, 2017(A1)

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

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

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

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 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

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

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

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 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

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 24 day of February 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CHAD CAMPS - (A1)

Service Area Office /
Bureau régional de services : Sudbury