Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 9, 2014	2014_293554_0035	O-000990-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North OSHAWA ON L1J 4L1

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

EXTENDICARE HALIBURTON
167 PARK STREET P.O. BOX 780 HALIBURTON ON K0M 1S0

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

KELLY BURNS (554), JOANNE HENRIE (550), RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 06-10 and October 14-17, 2014

Concurrent intakes were completed during this inspection: Log #O-000657-14, O-000547-14 and #O-001126-14

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Clinical Coordinator, Office Manager, Nursing Clerk, Dietary Manager, Activity Manager, Maintenance Worker, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Registered Dietitian, Housekeeping Staff, Activity Staff, Physiotherapist, Residents and Family

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

14 WN(s)
4 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	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. 53. Responsive behaviours

Specifically failed to comply with the following:

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

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 failed to comply with O. Reg. 79/10, s. 53 (3) (b), by ensuring that the responsive behaviour program is being evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

Administrator / Director of Care(ADM/DOC) indicated that the home has not yet completed a program evaluation for the current year specific to responsive behaviours nor was one completed in previous year.

Admin/DOC indicated a program evaluation specific to responsive behaviours was not an

expectation prior to this year for the home. [s. 53. (3) (b)]

2. Related to Log #O-000657-14, for Resident #09, 11 and 43:

The licensee failed to comply with O. Reg. 79/10, s. 53 (4), by ensuring that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to these behaviours, and 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.

Related to Resident #43:

Resident #43 was admitted to the home and was known to have a long standing history of responsive behaviours.

Physician's notes, on a specific date, indicate a trial of changing medications, may help, but in any case the specific responsive behaviour exhibited by the resident is not greatly amenable to medications. Resident is slowly worsening and staff are working diligently to monitor and modify behaviour, but unless resident has specific interventions while awake it is not possible to ensure resident or others are completely safe.

Progress Notes, written by registered nursing staff, for the period reviewed detail numerous responsive behaviour despite staff's presence.

Progress notes indicate that redirection or planned interventions are at times ineffective. There are some progress notes during the period reviewed where registered nursing staff have detailed Resident #43 exhibiting a responsive behaviour but progress notes fail to identify staff intervention and or the response of the resident.

During the above time period Resident #43 was on occasion slapped, kicked, hit with a toy or shooed away by other residents, despite staff presence.

Administrator / Director of Care indicated that increased staffing was implemented on a specific date to assist with planned interventions for Resident #43.

Staff and Residents interviewed did indicate that responsive behaviours are better managed with the increased staffing but that Resident #43 continues to present a

challenge with responsive behaviours exhibited.

Administrator / Director of Care and Clinical Coordinator (#101) did comment Resident #43 was referred for assessment with PASE but the consult has yet to have occurred.

It is to be noted, that the home has been diligently trying to manage the responsive behaviour of Resident #43, but resident remains a potential risk of harm not only to self but to other residents residing in the home.

The licensee failed to ensure:
- actions taken to meet the needs of the resident with responsive behaviours included reassessment, interventions and documentation of the resident's response to the interventions. (554)

2. Related to Resident #09:

Resident #09's family indicated resident's behaviours have changed recently and indicated that such may be related to declining health.

Progress notes for the period reviewed indicated Resident #09 as exhibiting numerous responsive behaviours.

Responsive Behaviours were not identified in the written care plan for Resident #09.

Resident #04 who shares a room with Resident #09 indicated resident exhibits responsive behaviours most nights and commented that it was very difficult to sleep. Resident #04 commented that staff do come into the room to see why resident is awake but once staff leave the room the responsive behaviour begins again. Resident commented that the concern regarding the responsive behaviours has been addressed with the ADM/DOC but the situation remains unresolved.

Staff #111 indicated Resident #09 exhibits responsive behaviours a lot at night; resident keeps co-residents awake at night. Staff #111 was unaware of any behavioural triggers for this resident.

Staff #102, who is one of the night charge nurses indicated not much can be done to stop Resident #09 from exhibiting responsive behaviours. Staff indicated that many nights resident sleeps in a chair at the nursing station or in the lounge; staff commented that

this was not a planned intervention for this resident.

Staff #101 and the RAI Coordinator, who along with other registered nursing staff are responsible for updating the care plans, commented that Resident #09's care plan, should have reflected responsive behaviours as an area of focus for this resident.

The licensee failed to ensure:
- behavioural triggers had been identified for the resident demonstrating responsive behaviours
- strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible
- actions taken to meet the needs of the resident with responsive behaviours included reassessment, interventions and documentation of the resident's response to the interventions (554)

3. Related to Resident #11:

Resident #11 has a history of challenging responsive behaviours and has been seen in the past by a support consultant; last consultation was approximately a year ago.

Progress notes, written by registered nursing staff, for the period reviewed documented numerous responsive behaviours exhibited by Resident #11.

Progress notes for the period above, detail interventions tried; notes indicate that interventions were often ineffective and that Resident #11 continued to exhibit responsive behaviours.

The written care plan describes Resident #11 as exhibiting responsive behaviours, but there is no noted triggers specified for these behaviours.

Resident #11 was seen by a physician on an identified date, the following was documented in the progress note, chronic behaviour problems have been worse despite changes in medications; questioning if a repeat visit with the Behaviour Consultant would be of benefit. Note: No referral was seen in Resident #11's health record, despite the responsive behaviours being identified as worsening.

Resident #11 was observed, on an identified date during specific time periods, exhibiting responsive behaviours.

During the above observation, one resident told Resident #11 three times to 'be a good'; after approximately twenty minutes of Resident #11 shouting, one resident shouted across the dining room 'shut up'.

Resident(s) #04, #07 and #13 all indicated that Resident #11's behaviours are worsening lately; all three resident's commented as to Resident #11 responsive behaviours not only in the dining room at meal time but also occurring during the night, which all three indicated most upsetting.

Resident #07 indicated Resident #13 and #11 often get into a shouting match and then Resident #11 will throw items into the hallway.

Resident #04, #07 and #13 indicated voicing their concern to the Administrator/Director of Care but the situation has yet to be resolved. Administrator indicated awareness of the complaint but indicated no resolution to the situation as of this time.

Staff #102, a charge nurse in the home, commented that resident exhibits responsive behaviours for no apparent reason and interventions are rarely effective. Staff #102 and #103 had no awareness if a referral with a community support agency had been ordered.

Administrator/Director of Care indicated awareness of the Resident #11's responsive behaviours worsening but commented that such may be related to medications being adjusted. Admin/DOC had no awareness of the suggestion, by the on-call physician, for Resident #11 to be seen by the community support agency but did indicate she would address with primary physician during the doctor's next visit to the home.

Admin/DOC indicated resident's responsive behaviours were a challenge for the staff and residents and agreed that interventions are rarely effective in reducing the incidences.

Resident #11's responsive behaviours present a potential risk of harm not only to the resident but to other residents residing in the home.

The licensee failed to ensure:
- behavioural triggers had been identified for the resident demonstrating responsive behaviours
- actions taken to meet the needs of the resident with responsive behaviours included

reassessment, interventions and documentation of the resident's response to the interventions

In the Home's Correction Action Plan, completed at an earlier date, indicated that for all resident's exhibiting responsive behaviours the following would be completed:
- an assessment of identified responsive behaviours
- that the team would identify behavioural triggers and plan appropriate interventions for each individual resident
- follow up assessments of the effectiveness of planned interventions
- early involvement of external supports (e.g. PASE) for assessment and care planning support
-all documentation was to include, behaviour exhibited by the resident, risk associated, identified triggers, interventions and assessment of the effectiveness of the intervention
- care plans are to be at all times reflective of the resident's current status

Administrator / Director of Care was in agreement that the corrective action plan to achieve compliance with O. Reg. 79/10, s. 53 (4) was not complied with for all resident's residing within the home with responsive behaviours, as the focus was on achieving compliance with Resident #43.

Administrator /Director of Care indicated that it is the expectation that all resident care plans are to be reflective of resident care needs and that registered nursing staff are aware that if a resident is exhibiting a responsive behaviour that the behaviour, the identified trigger, staff action and resident response is to be documented in the progress notes.

A compliance order specific to O. Reg. 79/10, s. 53 (4) was previously issued during another inspection. (554)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Related to Resident #10:

The licensee failed to comply with LTCHA, 2007, s. 6 (1), by ensuring that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident.

Resident #10 was admitted to hospital for treatment and returned to the home on a specific date with orders for a specific treatment; according to physician's orders the treatment was discontinued on an identified date.

Resident #10 declined and was readmitted to hospital a few days later treated and was discharged back to the home three days later.

According to progress notes, hospital discharge records and output monitoring records, Resident #10 was readmitted to the home with a specific treatment measure.

The written care plan identified resident as being incontinent. There is no indication in the written care plan as to Resident #10 having a specific treatment in place.

Registered Nursing Staff #109 and #101, who were interviewed did not realize Resident #10 had a specific treatment in place, despite resident having had a treatment measure since return from hospital.

Administrator/Director of Care indicated that the expectation is that the written care plan be reflective of the planned care for each resident, which in turn provides direction to care staff. [s. 6. (1)]

2. Related to Resident #29:

Resident #29 was observed to have a crusted large reddened area on their skin.

Progress notes, written by the physician, documented awareness of the crusted area on the resident's skin; the physician recommended that a specific treatment be used to gently lift the crusting patch.

Staff #123, who is a registered nurse, indicated any alterations in skin integrity are placed in the wound care book; Staff indicated that this is where all wounds that require assessment, treatment and documentation are kept. Staff #123 completed the resident-specific wound care page and indicated that there was no documentation as to the crusted skin patch for Resident #29. Staff #123 confirmed there was no entry in the wound care book regarding the required treatment for Resident #29. Staff #123 proceeded to enter that the resident had an identified skin issue and the required treatment in the wound care book.

Staff #124 and #125 both indicated that they were aware that treatment was to be used when caring for the resident; both staff indicated that they had carried out this care intervention for the resident. Staff indicated that any changes to the resident's altered skin integrity on the resident's skin was to be reported to the registered nurse.

Progress notes indicate that a treatment was applied to identified skin issue by Staff #123, after the interview with the inspector.

There is no care intervention specific to the skin issue for Resident #29 identified in the care intervention task sheets used by the PSWs; nor was there any care interventions identified in the Resident #29's care plan specific to the skin condition. [s. 6. (1) (c)]

3. Related to Resident #09:

The written care plan for Resident #09 indicates the following:

- Eating – has visual limitations; resident now needs to be fed

- Nutritional Status high risk related to medical conditions and unplanned weight loss – assist resident with meals; meat and bulky items need to be cut up into bite size pieces. Nursing Staff will monitor progress and give assistance when necessary. Resident is on a regular diet, modified texture.

According to the physician's orders, Resident #09 was ordered a modified diet texture months earlier.

Staff #101, who is a charge nurse was unsure why the written care plan indicted resident as needing both total assistance at meals and to be given assistance as necessary, nor why the care plan indicated staff as needing to cut up food into bite size pieces, despite a diet ordered for modified diet texture; staff indicated that the written care plan was confusing.

Staff #101, who is the charge nurse, did indicate Resident #09 should be receiving total assistance with all meals and according to the order dated months earlier. [s. 6. (1) (c)]

4. Related to Resident #10:

Resident #10 is at known risk of falls. Resident is no longer walking and requires total assistance by staff for all transfers.

The written care plan failed to identify how Resident #10 is to be transferred. The care plan for the quarter prior also did not identify transferring as an area of focus for Resident #10, despite resident requiring assistance of staff.

Progress notes reviewed indicate staff as transferring resident using a two person manual transfer and at other times using a mechanical lift.

Registered Nursing Staff #101 and Staff #103 both were unsure why the written care plan did not have a focus of how Resident #10 was to be transferred. Staff #101 indicated staff should be using a mechanical lift at all times to transfer this resident. [s. 6. (1) (c)]

5. Related to Resident #10:

The licensee failed to comply with LTCHA, 2007, s. 6 (10)(b), by ensuring that a resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #10 was admitted to the hospital, was treated for a medical condition and discharged back to the long term care home. According to hospital discharge records, the resident was readmitted back to the home with a specific treatment.

Physician’s orders for the period reviewed failed to provide evidence of any doctor’s orders for the treatment measure nor was there a review or reassessment of the need for the treatment measure.

The written care plan identified Resident #10 as being toileted AM, PM and after meals; indicating resident as having incontinence, despite the resident being observed as having a treatment measure in place.

Administrator /Director of Care and the Clinical Coordinator both indicated that a treatment order should have been obtained on readmission to the home following hospitalization and that the plan of care should have been updated to reflect changes in resident’s care needs. [s. 6. (10) (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 there is a process in place to monitor written plan of care for each resident that sets out, the planned care for the resident, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident; and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 16, by ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The following windows were observed to open greater than 15 centimetres:
- Melody Hallway, Resident Room(s) #1 (one window), #2 (one window), #4 (one window), #6 (one window), #7 (one window), #9 (two windows), #10 (two windows), and #11(two windows)

Further observations, during the next day, indicated that windows in resident rooms on both Harmony and other rooms on Melody halls also opened greater than 15 centimetres.

According to staff interviewed, there are residents residing within the home with a known history of wandering and or exit seeking.

The Administrator/Director of Care indicated no awareness of the windows in the home opening greater than 15 centimetres. Admin/DOC indicated inspector would need to speak with the Maintenance Worker(Manager) in the morning.

The Maintenance Worker stated awareness of the window opening greater than 15 centimetres but commented 'didn't feel there was a safety risk to residents due to the positioning of the window opening'.

Prior to the conclusion of the inspection, all windows were in keeping with O. Reg. 79/10, s. 16. [s. 16.]

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 there is a process in place to monitor that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. Related to Resident #30:

The licensee failed to comply with O. Reg. 79/10, s. 52 (1) 4., by ensuring that the pain management program provides the monitoring of resident responses to and the effectiveness of pain management.

Resident #30 indicated experiencing chronic discomfort for years and that recently there has been a change in severity and location of the discomfort. The resident indicated 'was now experiencing discomfort on a daily basis'.

Staff #113 indicated awareness that resident had a experienced a change in discomfort, both location and severity. Staff #113 indicated that resident had expressed experiencing discomfort to a specific area. Staff #113 indicated awareness Resident #30 was choosing to stay in bed for most of the day to read and this was contributing to the discomfort resident was experiencing.

Staff #113 indicated that Resident #30 is administered medication for comfort and the medication was being monitored for effectiveness.

Resident #30's current care plan indicates that the goal for discomfort management is for the resident to describe discomfort at a level of 4 or less, that registered nursing staff are to monitor the effectiveness of the analgesic and to adjust the analgesic as needed.

Progress notes for the period reviewed detail resident vocalizing discomfort twenty times during this time period(18 of the 20 times, the discomfort level was greater than 4) and being administered an analgesic by registered nursing staff. There is only one documented progress note detailing the effectiveness of the medication administered for the Resident’s #30 discomfort.

The Administrator /Director of Care (ADM/DOC) indicated that the expectation is for all registered nursing staff to monitor the effectiveness of discomfort of residents and to document the effectiveness of pharmacological approaches to manage resident's discomfort. The ADM/DOC confirmed that any resident experiencing discomfort at a level of 4 out of 10 or higher should have an assessment completed.

The ADM/DOC indicated that staff are to notify ADM/DOC of any change in health status for each resident at the home. [s. 52. (1) 4.]

2. Related to Resident #30:

The licensee failed to comply with O. Reg. 79/10, s. 52 (2), by ensuring that when a resident’s pain is not relieved by initial intervention, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #30 indicated experiencing chronic discomfort for years and recently there had been a change in severity and location of the discomfort. The resident indicated 'now experiencing discomfort on a daily basis'.

Resident #30's current care plan indicated that the goal for pain management is that resident will describe discomfort at a level of 4 or less. The plan of care reads that the registered nursing staff are to monitor the effectiveness of the analgesic and adjust the analgesic as needed.

Staff #113 indicated being aware that Resident #30 had a change in discomfort, both

location and severity. Staff #113 indicated that resident had expressed experiencing discomfort to a specific area. Staff #113 indicated being aware that the resident was choosing to stay in bed for most of the day, and this was contributing to resident's discomfort. Staff #113 indicated that the resident is administered analgesic and is monitored to determine if the medication is effective. Staff #113 indicated that the home has a assessment tool which should have been completed with the change in severity and location of the discomfort for this resident.

Staff #114 indicated being aware that the Resident #30 had voiced complaints regarding discomfort, and this was a change in location from resident's previous complaints. Staff #114 indicated that an assessment was completed for the resident.

Progress notes, for the period reviewed, detail that Resident #30 as vocalized discomfort and resident being administered an analgesic, by registered nursing staff. During the period indicated above the resident vocalized discomfort a total of 20 times, there is only one documented progress note detailing the effectiveness of the medication administered to Resident #30. Progress notes, for this same period, detail Resident #30 having voiced discomfort at a level higher than 4, 18 out of the 20 times.

The home’s policy Pain Management (RESI-10-03-01) states that each resident will be assessed for pain with a change in condition associated with the onset of pain and screen daily. The policy further states, that an indicator for completing a pain assessment would include, a resident stating they have new pain 4 out of 10 or greater.

Staff #114 confirmed that there was no pain assessment completed for the Resident #30, when resident began to vocalize having discomfort.

The Administrator/Director of Care indicated overseeing the pain management program for the home. The ADM/DOC indicated that a pain assessment tool is to be completed by registered nursing staff when a resident has a change in pain severity and location. The ADM/DOC indicated that no awareness that a pain assessment was not completed for this resident as required by the home's policy. [s. 52. (2)]

3. Related to Resident #18:

Resident #18 had a fall on a specific date and sustained injuries. A progress note, on an identified date, and written by the home’s physician indicate the resident may have a potential medical condition as a result of the fall. A care measure was ordered for

treatment and or comfort of Resident #18. The physician, further indicated, that there was no need for diagnostic test as the treatment for the injury would remain the same.

According to the health record, Resident #18 had recently experienced a decline in health status.

Resident #18's current care plan detailed non-pharmacologic measures for pain management including the use of specific interventions specific to the injury. Resident #18's current care plan documented that the resident's discomfort level will be diminished from level 7 to 3 (to one area) over the three months and discomfort level will be reduced from level 5 to 2 for another area.

A review of the physician orders, did indicated resident had an order for an analgesic as needed. It is noted that the resident was administered the analgesic as documented in the progress notes several times during the period reviewed.

Staff #109 and Staff #101, both registered nursing staff, indicated Resident #18 should have had a pain assessment completed after the identified fall incident; both staff indicated that they were aware of Resident #18's discomfort and that an analgesic had been ordered for resident's discomfort. Staff #109 confirmed that the home's policy provided the scale for assessing resident discomfort; staff indicated being aware that a discomfort level described to be greater than 8 is considered to be severe discomfort. Both registered nursing staff confirmed that when there is a change in a resident’s condition regarding discomfort severity an assessment, using a specific assessment tool, should have been completed.

The home’s policy, Pain Management (RESI-10-03-01) states that each resident will have a pain assessment completed when a new pain medication is introduced for greater than 72 hours and when a resident vocalizes they have new pain 4 out of 10 or greater.

Progress notes reviewed document that the Resident #18's discomfort level to an identified area was recorded as a level 8. Progress notes, documented on a specific date, detail resident's discomfort level of the identified area to be at a level 9; progress notes for a specific time period detail several entries where Resident #18 voiced complaints specific to the severity of discomfort, which was vocalized to be at levels of 7 or higher.

A narcotic analgesic was ordered and could be given every eight hours as needed.

According to the electronic Medication Administration Record, Resident #18 received 17 doses of a medication between a 7 day period. A review of the Resident #18's health care record failed to provide evidence that an assessment, using a specific assessment was completed with the introduction of a new medication.

Staff #123, who is a registered nursing staff, indicated not being aware that a assessment was required to be completed with the introduction of a new medication.

Administrator/Director of Care indicated that it is the expectation for registered nursing staff to follow the policy and to complete a pain assessment with a change in pain severity as well as with the introduction of a new pain medication. [s. 52. (2)]

4. Related to Resident #32:

Resident #32 indicated experiencing discomfort. Resident #32 indicated having been given medication for the discomfort and that the medication helped with the discomfort.

During a record review, progress notes indicate resident was administered an analgesic on a specific date. It is further documented that the analgesic was administered for the discomfort which was scored at 6/10. A secondary entry dated approximately two weeks later detail resident's discomfort as being 8/10.

Staff #123 indicated being aware that the resident has been experiencing discomfort; staff indicated assessing the resident for discomfort. Staff continued to monitor the resident. Staff #123 indicated that an assessment would not have been completed, as the resident's discomfort was intermittent and not a chronic issue.

The home's policy, Pain Management(RESI-10-03-01) states that each resident will be assessed for pain with a change in condition associated with the onset of pain and screened daily.

The policy further states that an indicator for completing a pain assessment would include: a resident stating they have new pain 4 out of 10 or greater.

The Administrator/Director of Care indicated that the home's policy for pain management is to assess residents who are experiencing new pain and pain with a severity level of 4 or higher.

The ADM/DOC confirmed that a pain assessment should have been initiated when the resident had indicated that the pain level was great than 4. [s. 52. (2)]

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 there is a process in place and monitored ensuring that residents are being monitored for the presence of pain and that their response and effectiveness of medication is being monitored; and that when a resident's pain is not relieved by initial intervention, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #5: 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,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in

the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (2)(d), by ensuring the Infection Prevention and Control program evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Administrator / Director of Care indicated that there has not been a program evaluation for the current year nor was the Infection Control Program evaluated in previous year. [s. 229. (2) (d)]

2. The licensee failed to comply with O. Reg. 79/10, s. 229 (3), by ensuring that there is a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices.

Administrator/Director of Care indicated that Staff #101 was the Infection Control Lead for the home.

Staff #101 indicated taking the role of Clinical Coordinator/ Infection Control as of a specific date but indicated that this was only a temporary posting. Staff #101 indicated having no education or experience relating to infection prevention and control. [s. 229. (3)]

3. The licensee failed to comply with O. Reg. 79/10, s. 229 (10) 1., by ensuring that each resident admitted to the home screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

The Administrator/Director of Care (Admin/DOC) indicated that the home is currently screening all newly admitted residents for tuberculosis (TB) within 14 days of admission to the home.

TB Testing noted in the home's records indicated that 5 residents (randomly selected) admitted to the home had not received screening or had been screened for tuberculosis outside of the testing parameters.

The Administrator/Director of Care and the Infection Control Lead had no awareness that the above residents were not screened for tuberculosis within 14 days of admission. [s. 229. (10) 1.]

4. The licensee failed to comply with O. Reg. 79/10, s. 229 (10) 2, by ensuring that residents offered immunization against influenza at the appropriate time each year.

According to the home's immunization records, three residents, randomly selected had

consented to the administration of influenza vaccination but had not received immunization as requested.

The home's policy Resident Vaccinations (INFE-02-01-04) indicates that a comprehensive vaccination history will be obtained for all residents admitted to the home. Annual influenza vaccination as recommended by the local Public Health Authority is strongly recommended for all residents residing in the home.

According the policy Resident Vaccinations, the home is to be following Health Canada (2006) Canadian Immunization Guide, which indicates Adults at high risk of influenza-related complications, should receive the Influenza Vaccination – 1 dose annually.

Administrator/Director of Care and Infection Control Lead indicated no awareness of the above residents not being offered the Annual Influenza Vaccination. [s. 229. (10) 2.]

5. The licensee failed to comply with O. Reg. 79/10, s. 229 (10) 3., by ensuring that residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

According to the home's immunization records, four residents, randomly selected consented to receiving the pneumococcus and or tetanus/diphtheria vaccination but had not received such despite their wishes.

The home's policy Resident Vaccination (INFE-02-01-04) indicates that a comprehensive vaccination history will be obtained for all residents admitted to the home. The policy directs that vaccination for pneumonia and diphtheria/tetanus will be offered upon admission if vaccination status is not current with Health Canada Guidelines.

Administrator/Director of Care and Infection Control Lead indicated no awareness of the above residents not being offered immunizations as indicated above. [s. 229. (10) 3.]

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 process are in place to monitor each resident admitted to the home screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee; the licensee will further ensure that a process is in place to monitor that residents offered immunizations against influenza, pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules, to be implemented voluntarily.

WN #6: 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 :

1. Related to Resident #27:

The licensee failed to comply with O. Reg. 79/10, s. 8 (1) (b), by ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is, complied with.

The home's policy, Nutritional Assessment (Diet-04-01-03) indicates that the Registered Dietitian must ensure that all staff and others who provide care to the residents are kept aware of the nutritional intervention in the resident's care plan.

Resident's #27 health care record identifies resident as a High Nutritional Risk, on a specific date due to the resident's significant weight change, and other medical conditions. It is noted that the resident's weight was monitored on a monthly basis; there are several entries in the progress notes written by the RD. The care plan was revised, on an identified date, by the Registered Dietitian (RD) specified a target amount of fluid intake of fluids per day for Resident #27.

Staff #101 indicated that all dietary changes are communicated at report from registered nursing staff to staff when they are aware of changes in resident's dietary needs. Staff #101 indicated not being able to find any indication that the resident's nutritional intake had been changed by the RD.

The ADM/DOC indicated that referrals are made by registered nursing staff to the dietitian for those residents who have had a weight loss or issues with food intake. The DOC indicated the RD reviews all referrals and completes an assessment of the resident, and further commented that should there be a change in the residents' nutritional intake the RD would write an order on the physician order sheet and flag the chart for registered staff. The DOC indicated that registered nursing staff review all orders and input this information into the resident's health record.

The DOC reviewed the resident's physician order sheet and confirmed that there were no orders made by the RD for this nutritional intervention. [s. 8. (1) (a),s. 8. (1) (b)]

2. Related to Resident #13:

A container of medicated cream was observed on the bedside table in Resident #13's room. Resident indicated having a skin condition and that the cream was to be applied to hands on a daily basis; resident indicated self administering this medicated cream.

The medicated treatment cream on the bedside table did not indicate that the cream was to be applied to hands, but to another area of the resident's body.

The home's policy, Self Administration (CLIN-11-23) indicated that registered nursing staff are to assess the resident's cognitive ability to self administer medication.

The policy further indicates that progress notes should be used to document the assessment and decision making process that was undertaken to determine if the

resident is able to self administer medications. Any observations regarding a resident's ability or lack of ability should be documented as well.

Resident #13 has a physician's order indicating a medicated cream was to be applied to a specific body area twice daily; resident may self administer. A review the resident's health record was completed, inspector was unable to find documentation of an evaluation or any assessment that was done to assess the resident's cognitive ability to self administer medication.

Staff #123 indicated that Resident #13 still has the medicated cream at bedside, and resident applies to body area twice daily when needed. Staff #123 indicated that any resident who self administers medications need to be evaluated by the staff or the doctor to ensure they comprehend how to take the medication and what it is being used for and this would be documented in the progress notes or under assessments in the resident's chart. A review of the health record for a specific time period failed to provide supporting documentation in regards to this. Staff #123 indicated it was not done for this resident. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (a) by ensuring the home, furnishings and equipment are kept clean and sanitary.

The following observations were made during the inspection:

- Toilet – dark brownish/black staining on the caulking (or sealant) surrounding the base of the toilet/flooring in room(s) #1, 2, 6, 7, 9, 10, 11, 14, 15, and 20
- Room #11 – brownish/rust colour staining on files in front of and surrounding toilet in the washroom
- Drapes in Room #1 and #2 – were soiled (brownish stains)
- Washroom Flooring – brownish/black debris built up along base of flooring and wall, especially in the corners in Room(s) #1, 2, 6, 7, 9, 10, 14, 15, 19 and 20 – debris easily scrapes off using a pen
- Bedroom Flooring – black scuff marks visible on flooring in room #6
- Laminate Flooring in washroom (room) #1 cut shorter than requirements / missing threshold in Room #1 and #6 – debris and dust visible on sub-flooring – easily scrapes off with use of a pen

Administrator / Director of Care who oversees the operation of the Housekeeping department indicated no awareness of the housekeeping issues presented above but did indicate concerns would be discussed with Housekeeping department. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the inspection:

- Walls (resident room or washroom) are scuffed (black marks), paint chipped, dry wall compound visible or damaged in Room #3, 6, 7, 14, 15, 16, 19, 20, 25, 27 and one tub room
- Door Frames in resident rooms or washrooms are chipped in Room # 1, 6, 9, 10, 14, 19, 20 and 25
- Flooring - is lifting or laminate missing in Room #1 and 6; the exposed sub flooring has dust and debris visible
- Flooring – tub room (1) – seam of flooring split
- Tub Room – Prelude tub – acrylic inside tub is chipped
- Room #19 – closet wall adjacent to door is being held together masking tape
- Harmony Hallway Flooring – is 'bubbling' outside of Room #14
- Wall Guard lifting or loose – communal washroom (Melody Hallway) and outside of Room #4 and #5
- Resident Patio Area – concrete chipped or uneven

- Room #6 – baseboard heater is missing cover; sharp edges exposed
- Room #6 – over bed light missing pull string
- Furnishings - torn chair (home owned) in Room #2

The Maintenance Log Book was reviewed and failed to identify any of the above areas.

Administrator / Director of Care (ADM/DOC) indicated the home did have a 5 year painting schedule/plan and Maintenance Worker (Manager) does try to paint rooms on a priority bases as needed.

ADM/DOC was aware of areas requiring painting in the home, but was not aware of the other maintenance concerns identified during the above observations. [s. 15. (2) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to Resident #08, 10 and #12:

The licensee failed to comply with O. Reg. 79/10, s. 26 (3) 21., by ensuring the plan of care based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

The following observations were made:
- During the second day of the home's inspection, Resident's #08, 10 and #12 were not at breakfast; identified residents were still in bed sleeping except Resident #08 who was provided a meal tray. There were several other resident's also identified as not attending breakfast or arriving late during this observation.
- During the third day of the home's inspection, Resident #10 and #12 were not to breakfast until an hours and a half after the start of the meal.
- During the fourth day of the inspection, Resident #12 was not to breakfast until an hour after the meal starting.

The breakfast meal for this home is scheduled to begin at 08:00am

Care Plan Review:
- Resident # 08, #10 and #12's care plan(s) did not identify that resident's preference was to sleep late into the morning nor did it include any sleep pattern preference

The Administrator/Director of Care indicted awareness of residents not arriving on time for breakfast, indicating the home allows residents to gently wake on their own unless otherwise indicated by the resident.

ADM/DOC indicated that there is no documentation to support residents being assessed as to their sleep pattern or preference. [s. 26. (3) 21.]

WN #9: 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 failed to comply with O. Reg. 79/10, s. 37 (1) (a), by ensuring 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.

The following observations were made during the dates of the inspection:

- Room #9 – an orange nailbrush, two toothbrushes, two tweezers, one brush and a comb were lying on the bathroom counter or on a shelf over the toilet, all items were unlabelled; this is a shared washroom (4 residents)

- Room #10 - stick deodorant, and a toothbrush were lying on the bathroom counter, all items were unlabelled; this is a shared washroom (4 residents) [s. 37. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Related to Resident #10:

The licensee failed to comply with O. Reg. 79/10, s. 49 (2), by ensuring that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #10 has a history of falls due to health and physical limitations.

According to progress notes and Risk Management Incidents for the period of reviewed, Resident #10 sustained numerous falls during this time period. Injuries occurred as a result of the majority of Resident #10's falls.

The written care plan does indicate 'falls' as an area of concern but fails to provide Resident #10's falls risk level.

The MORSE Fall Assessment (Scale) for Resident #10 was last completed approximately a year ago.

The home's policy Falls Prevention and Management Program (RESI-10-02-01) directs that an MORSE Fall Risk Assessment will be completed on admission, when a Fall RAP is newly triggered in the MDS Assessment and at the time of a significant change in resident status.

The Administrator /Director of Care indicated that at MORSE FALLS Scale Assessment should have been completed on Resident #10 due to the number of falls sustained and change in resident's mobility and health status. [s. 49. (2)]

2. Related to Resident #18:

A review of Resident #18's health record indicated, that to date in the current year, Resident #18 had fallen numerous times during a specific time period.

The health record for Resident #18 indicated that a falls risk assessment was done upon admission, when resident was identified as being at moderate risk for falls.

There was no other falls risk assessments completed for this resident. [s. 49. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Related to Resident #10:

The licensee failed to comply with O. Reg. 51 (2)(a), by ensuring that resident who is incontinent received an assessment that:

• includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and
• is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require

Resident #10 was admitted to the hospital for treatment of a medical condition and returned to the home following the treatment. Resident returned to the home with orders for a specific treatment.

Physician's orders indicate the treatment was removed approximately four days following resident's return from hospital.

Resident #10's health declined, requiring the need to transfer resident back to the local hospital; resident was admitted to hospital for further treatment and returned to the home three days later. According to the hospital discharge records, Resident #10 returned to the home with a specific treatment measure in place.

There is no indication that a continence assessment was completed for Resident #10 during the above time period. The last continence assessment on file for this resident was a year and a half earlier, which indicated resident as being incontinent.

The home's policy Continence Management Program (RESI-10-04-01) directs that staff will complete a continence assessment using a clinically appropriate assessment tool upon admission, with any deterioration of continence level and with any change in condition that may affect bladder continence.

Staff #101, who is both a charge nurse and the Clinical Coordinator indicated that a continence assessment should have been completed for Resident #10 upon return from hospital and when resident became ill prior to hospitalization. [s. 51. (2) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that the written procedures under section 21 of the Act to incorporate all the requirements set out in section 101.

As per O. Reg 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

The home's policy Complaints (09-04-06) has no provision for this requirement in the policy.

During an interview the Administrator/Director of Care indicated the home's policy does not indicate that where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commence immediately. [s. 100.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 101 (2) by ensuring that a documented record is kept in the home that includes:

(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

A review the home's complaint binder provided by the Administrator/Director of Care, indicated there were 17 complaints lodged to date in the current year. On the complaint

log sheet there is a column to indicate the outcome of the complaint but there is no outcome documented for each of the 17 complaints. There is also a column to indicate actions taken by the licensee or its designate, including the time frames for actions. For all of the 17 registered complaints the nature of the complaint is documented in this column, but there is no documentation of the actions taken by the licensee or its designate including the time frames for actions.

There is a compliment/concern sheet filled out for complaint #16; on this form the action taken and follow-up with the complainant is registered. This is the only complaint to have actions taken documented.

The Administrator/Director of Care indicated recently noticing some information is missing on the complaint log sheet. The missing information includes:
- the action taken is not documented, including the date of the action, time frames for actions to be taken and any follow-up action required,
- the final resolution,
- every date on which any response was provided to the complainant and a description of the response, and
- any response made by the complainant

This information can be found on the compliment/concern sheet, ADM/DOC indicated failing to complete the required documentation on the complaint log form. [s. 101. (2)]

2. The licensee failed to comply with O. Reg. 79/10, s. 101 (3) (a) by ensuring that, the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly.

A review of the home's complaint log binder failed to provide evidence that complaints received for the ten month period were reviewed and analyzed for trends.

Administrator/Director of Care indicated that complaints received for current year have not been reviewed and analyzed for trends quarterly during the current year nor during the previous year. [s. 101. (3)]

WN #14: 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 :

1. Related to Resident #29:

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

Staff #109, who is a registered practical nurse, was observed giving medication to residents. Staff #109 indicated that there is one registered nursing staff to administer medications to all sixty residents and that on most days, the medication administration pass begins at 8:00am and does not finish until approximately 10:30am; the medication administration pass for the noon medication pass, begins at 12:00pm and does not finish until 2:00pm.

Resident #29 had a prescription for a narcotic analgesic, to be administered three times daily; the medication was supposed to be administered at 12:00pm. Inspector observed that the medication was documented by staff #109 on the narcotic administration sheet as being given to Resident #29 at 12:00pm. Inspector observed the actual medication was not administration until 13:19pm according to the electronic medication record.

During an interview the Administrator/Director of care indicated no awareness that the medication pass took that much time on a daily basis and the home's expectation is that all the medications are to be administered 1 hour before and up to 1 hour after the prescribed time. [s. 131. (2)]

Issued on this 10th day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554), JOANNE HENRIE (550), RUZICA SUBOTIC-HOWELL (548)
Inspection No. / No de l'inspection :	2014_293554_0035
Log No. / Registre no:	O-000990-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 9, 2014
Licensee / Titulaire de permis :	EXTENDICARE CENTRAL ONTARIO INC 82 Park Road North, OSHAWA, ON, L1J-4L1
LTC Home / Foyer de SLD :	EXTENDICARE HALIBURTON 167 PARK STREET, P.O. BOX 780, HALIBURTON, ON, K0M-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JANE ROSENBERG

To EXTENDICARE CENTRAL ONTARIO INC, 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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_293554_0026, CO #001;

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:
- review and update all resident care plans to ensure responsive behaviours are identified for individual residents exhibiting behaviours, that triggers to behaviours are identified, and that for each behaviour strategies are to be identified to assist staff in managing responsive behaviours
- complete assessments when a resident is exhibiting a new responsive behaviour or if identified as having a worsening behaviour (the home's policy identified Dementia Observation Scale, Cohen Mansfield and Behavioural Assessment Tool)
- provide education to all registered nursing staff specific to care planning and documentation relating to resident responsive behaviours
- develop or implement a process to monitor that documentation includes identification of the responsive behaviour observed, triggers if any identified, action taken by the staff, and the response of the resident
- develop or implement a process to refer a resident to local community psychogeriatric resource for further assessment and care planning interventions if and when, a resident is not responding to non-pharmacological and or pharmacological interventions, a resident's responsive behaviours are escalating despite interventions implemented and or when a resident's responsive behaviour places the resident or others at risk of harm

Grounds / Motifs :

1. Related to Log #O-000657-14, for Resident #09, 11 and 43:

The licensee failed to comply with O. Reg. 79/10, s. 53 (4), by ensuring that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to these behaviours, and 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.

Related to Resident #43:

Resident #43 was admitted to the home and was known to have a long standing history of responsive behaviours.

Physician's notes, on a specific date, indicate a trial of changing medications, may help, but in any case the specific responsive behaviour exhibited by the resident is not greatly amenable to medications. Resident is slowly worsening and staff are working diligently to monitor and modify behaviour, but unless resident has specific interventions while awake it is not possible to ensure resident or others are completely safe.

Progress Notes, written by registered nursing staff, for the period reviewed detail numerous responsive behaviour despite staff's presence.

Progress notes indicate that redirection or planned interventions are at times ineffective. There are some progress notes during the period reviewed where registered nursing staff have detailed Resident #43 exhibiting a responsive behaviour but progress notes fail to identify staff intervention and or the response of the resident.

During the above time period Resident #43 was on occasion slapped, kicked, hit with a toy or shooed away by other residents, despite staff presence.

Administrator / Director of Care indicated that increased staffing was implemented on a specific date to assist with planned interventions for Resident #43.

Staff and Residents interviewed did indicate that responsive behaviours are better managed with the increased staffing but that Resident #43 continues to present a challenge with responsive behaviours exhibited.

Administrator / Director of Care and Clinical Coordinator (#101) did comment Resident #43 was referred for assessment with PASE but the consult has yet to have occurred.

It is to be noted, that the home has been diligently trying to manage the responsive behaviour of Resident #43, but resident remains a potential risk of harm not only to self but to other residents residing in the home.

The licensee failed to ensure:
- actions taken to meet the needs of the resident with responsive behaviours included
reassessment, interventions and documentation of the resident's response to the interventions. (554)

2. Related to Resident #09:

Resident #09's family indicated resident's behaviours have changed recently and indicated that such may be related to declining health.

Progress notes for the period reviewed indicated Resident #09 as exhibiting numerous responsive behaviours.

Responsive Behaviours were not identified in the written care plan for Resident #09.

Resident #04 who shares a room with Resident #09 indicated resident exhibits responsive behaviours most nights and commented that it was very difficult to sleep. Resident #04 commented that staff do come into the room to see why resident is awake but once staff leave the room the responsive behaviour begins again. Resident commented that the concern regarding the responsive behaviours has been addressed with the ADM/DOC but the situation remains unresolved.

Staff #111 indicated Resident #09 exhibits responsive behaviours a lot at night; resident keeps co-residents awake at night. Staff #111 was unaware of any

behavioural triggers for this resident.

Staff #102, who is one of the night charge nurses indicated not much can be done to stop Resident #09 from exhibiting responsive behaviours. Staff indicated that many nights resident sleeps in a chair at the nursing station or in the lounge; staff commented that this was not a planned intervention for this resident.

Staff #101 and the RAI Coordinator, who along with other registered nursing staff are responsible for updating the care plans, commented that Resident #09's care plan, should have reflected responsive behaviours as an area of focus for this resident.

The licensee failed to ensure:
- behavioural triggers had been identified for the resident demonstrating responsive
behaviours
- strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible
- actions taken to meet the needs of the resident with responsive behaviours included reassessment, interventions and documentation of the resident's response to the interventions (554)

3. Related to Resident #11:

Resident #11 has a history of challenging responsive behaviours and has been seen in the past by a support consultant; last consultation was approximately a year ago.

Progress notes, written by registered nursing staff, for the period reviewed documented numerous responsive behaviours exhibited by Resident #11.

Progress notes for the period above, detail interventions tried; notes indicate that interventions were often ineffective and that Resident #11 continued to exhibit responsive behaviours.

The written care plan describes Resident #11 as exhibiting responsive behaviours, but there is no noted triggers specified for these behaviours.

Resident #11 was seen by a physician on an identified date, the following was

documented in the progress note, chronic behaviour problems have been worse despite changes in medications; questioning if a repeat visit with the Behaviour Consultant would be of benefit. Note: No referral was seen in Resident #11's health record, despite the responsive behaviours being identified as worsening.

Resident #11 was observed, on an identified date during specific time periods, exhibiting responsive behaviours.

During the above observation, one resident told Resident #11 three times to 'be a good'; after approximately twenty minutes of Resident #11 shouting, one resident shouted across the dining room 'shut up'.

Resident(s) #04, #07 and #13 all indicated that Resident #11's behaviours are worsening lately; all three resident's commented as to Resident #11 responsive behaviours not only in the dining room at meal time but also occurring during the night, which all three indicated most upsetting.

Resident #07 indicated Resident #13 and #11 often get into a shouting match and then Resident #11 will throw items into the hallway.

Resident #04, #07 and #13 indicated voicing their concern to the Administrator/Director of Care but the situation has yet to be resolved. Administrator indicated awareness of the complaint but indicated no resolution to the situation as of this time.

Staff #102, a charge nurse in the home, commented that resident exhibits responsive behaviours for no apparent reason and interventions are rarely effective. Staff #102 and #103 had no awareness if a referral with a community support agency had been ordered.

Administrator/Director of Care indicated awareness of the Resident #11's responsive behaviours worsening but commented that such may be related to medications being adjusted. Admin/DOC had no awareness of the suggestion, by the on-call physician, for Resident #11 to be seen by the community support agency but did indicate she would address with primary physician during the doctor's next visit to the home.

Admin/DOC indicated resident's responsive behaviours were a challenge for the staff and residents and agreed that interventions are rarely effective in reducing

the incidences.

Resident #11's responsive behaviours present a potential risk of harm not only to the resident but to other residents residing in the home.

The licensee failed to ensure:
- behavioural triggers had been identified for the resident demonstrating responsive behaviours
- actions taken to meet the needs of the resident with responsive behaviours included reassessment, interventions and documentation of the resident's response to the interventions

In the Home's Correction Action Plan, completed at an earlier date, indicated that for all resident's exhibiting responsive behaviours the following would be completed:
- an assessment of identified responsive behaviours
- that the team would identify behavioural triggers and plan appropriate interventions for each individual resident
- follow up assessments of the effectiveness of planned interventions
- early involvement of external supports (e.g. PASE) for assessment and care planning support
-all documentation was to include, behaviour exhibited by the resident, risk associated, identified triggers, interventions and assessment of the effectiveness of the intervention
- care plans are to be at all times reflective of the resident's current status

Administrator / Director of Care was in agreement that the corrective action plan to achieve compliance with O. Reg. 79/10, s. 53 (4) was not complied with for all resident's residing within the home with responsive behaviours, as the focus was on achieving compliance with Resident #43.

Administrator /Director of Care indicated that it is the expectation that all resident care plans are to be reflective of resident care needs and that registered nursing staff are aware that if a resident is exhibiting a responsive behaviour that the behaviour, the identified trigger, staff action and resident response is to be documented in the progress notes.

A compliance order specific to O. Reg. 79/10, s. 53 (4) was previously issued during another inspection. (554) (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 13, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

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

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

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 9th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Burns

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