Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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

Ottawa Service Area Office
347 Preston St, 4th Floor
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347, rue Preston, 4iém étage
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 8, 2014 | 2014_293554_0026 | O-001178-13 | Follow up |

**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)

**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): May 23, 2014**

**Follow Up Inspection, for Log #O-001178-13, which is a follow up to compliance orders regarding Responsive Behaviour (from Inspection #2013_196157_0024)**

**During the course of the inspection, the inspector(s) spoke with Administrator-Director of Care, Registered Nurse, Registered Practical Nurse, Personal Support Workers, Residents, and Family**

**During the course of the inspection, the inspector(s) toured the home, reviewed resident health records, observed Resident #001, observed resident-staff interactions, reviewed the homes' policies specific to responsive behaviours, and reviewed staff education**

**The following Inspection Protocols were used during this inspection: Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. Related to Log # O-001178-13 - For Resident #001:

A follow up inspection was completed with regards to a Compliance Order issued under inspection #2013_196157_0024; the order was in relation to the home's management of responsive behaviours, specific to Resident #001, and was to be complied with by January 20, 2014.

Resident #001 has a history of responsive behaviours.

Resident #001 was observed during the inspection exhibiting the following responsive behaviours:
- wandering aimlessly in the hallways
- entering other residents' rooms
- touching co-resident's belongings, taking a blue sweater, a television remote control, and a book from residents rooms
- touching items on the nourishment cart
- picking up utensils from several dining room tables
- wandering in and out of the dining room during the lunch meal
- making squealing noises

On one occasion, during the inspection, Resident #001 was seen removing a yellow wandering strip and entering a room where four residents resided; a resident inside the room, began yelling at Resident #001 and told resident to get out of the room; the interaction between both residents lasted approximately 2-3 minutes before Resident #001 turned and exited the room.

Progress notes, written by registered nursing staff, for the period reviewed included numerous documented responsive behaviours exhibited by Resident #001.

The care plan reviewed, indicates the following areas of focus specific to responsive behaviours: disruptive to others, wanders, puts foreign objects in mouth, physical aggression and agitation.

The only trigger identified in the care plan, is in relation to physical aggression and or agitation, which mentions resident's behaviour is triggered by people telling resident what to do, telling resident 'no' and providing care when resident does not want it.

Staff interviewed were not aware of triggers for Resident #001's exhibited responsive behaviours which include but not limited to, wandering, touching others belongings, and eating substances or foreign objects. [s. 53. (4) (a)]

2. The licensee failed to comply with O. Reg. 79/10, s. 53 (4)(b), by failing to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours.

The written care plan for Resident #001, for the period reviewed, indicated some interventions specific to responsive behaviours but observations during the inspection indicated interventions as not implemented or were not effective.

The progress notes for the period reviewed, indicated staff implemented the following interventions when Resident #001 was exhibiting responsive behaviours:
- redirection
- redirection out of resident's rooms
- resident told not to do that
- offered a snack, following ingestion of substances or foreign items (2 times)
- poison control contacted (1 time)
- given toy (1 time)
- given PRN medication

Strategies such as giving resident a toy to care for, giving resident gum to chew, use of baby gates, reading and music were not observed implemented during the inspection.

Interviews with Staff #101, 102, 103 and 104 indicated Resident #001 continues to wander and touch others belongings despite interventions; staff interviewed indicated behaviours exhibited are normal for Resident #001.

Staff #101 indicated 'little can be done' and that resident's behaviour is upsetting to other residents.

Staff #104 indicated 'resident is very difficult to redirect', 'resident will go under the yellow banners on the doors or remove them'.

Resident #002 indicated displeasure with Resident #001 entering resident room and taking personal belongings. Resident indicated 'the staff tell me to call for help, but

they (staff) are slow to respond or don't come at all'. Resident indicated that Resident #001 shouts and often refuses to leave the room.

Resident #003 and #004 indicated Resident #001 frequently enters their rooms and stares at them or takes things, despite telling resident 'no'. Resident #003 indicated being yelled at by Resident #001, when resident was told to get out of the room. Both residents indicated that they were upset by Resident #001 behaviours and have been told by staff that there is nothing that can be done, other than to call for staff assistance when resident enters their rooms.

Resident #005 indicated Resident #001 has taken belongings from resident's room; resident indicated if needed, Resident #001 would be slapped if in resident's way or if takes things again. [s. 53. (4) (b)]

3. The licensee failed to comply with O. Reg. 79/10, s. 53(4)(c), by failing to ensure that actions taken to meet the needs of the resident with responsive behaviours include, reassessment, interventions and documentation of the resident's response to the interventions.

Progress notes for the period reviewed indicated Resident #001 as exhibiting responsive behaviours.

Progress notes for the period reviewed, indicated that interventions tried, such as redirection, telling resident 'no' and offering a snack, were ineffective and indicated Resident #001 continues to wander into other resident's room, touching their belongings.

Other progress notes for the same, detailed Resident #001 as exhibiting responsive behaviours but staff failed to identify action taken and or response observed.

Progress notes for the period above, detailed incidents of Resident #001 being yelled at by other residents and one occasion where resident was hit by another resident in retaliation.

Resident #001's health record indicated that last completed assessments on file for this resident were as follows:
- Dementia Observation Scale (DOS) – approximately one year ago
- Cohen Mansfield Agitation Scale – approximately one year ago

- Behaviour Assessment Tool (BAT) - approximately one year ago
- PASE Assessment – approximately two years ago

Staff interviewed indicated interventions are rarely effective in reducing or eliminating Resident #001's responsive behaviours.

Residents interviewed indicated they were told little could be done to stop Resident #001's behaviours and to call for staff assistance if resident enters their room.

Administrator / Director of Care (Admin/DOC) indicated that medications have been somewhat effective, but increasing the dosage has resulted in falls for the resident.

Administrator / Dihttp://localhost:46683/CSC/Inspection/OrderPublicCopy.aspxrector of Care indicated that Resident #001's responsive behaviors are challenging and was in agreement with staff that planned interventions have minimal or no effect on reducing incidence.

The responsive behaviours exhibited by Resident #001 continue to place the identified resident at risk of harm to self and other residents. [s. 53. (4) (c)]

***Additional Required Actions:***

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

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**Issued on this 17th day of July, 2014**

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

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) |
| **Inspection No. / No de l'inspection :** | 2014_293554_0026 |
| **Log No. / Registre no:** | O-001178-13 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Jul 8, 2014 |
| **Licensee / Titulaire de permis :** | EXTENDICARE CENTRAL ONTARIO INC<br>82 Park Road North, OSHAWA, ON, L1J-4L1 |
| **LTC Home / Foyer de SLD :** | EXTENDICARE HALIBURTON<br>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:

**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2013_196157_0024, 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 must prepare, submit and implement a plan for achieving compliance to ensure that behavioural triggers are identified and strategies developed to respond to responsive behaviours exhibited by Resident #001 and any other resident. The licensee will further ensure that actions taken to respond to the needs of Resident #001, including assessments, reassessments, interventions and that the resident's responses to the intervention are documented.

The home's plan must include:
- how and when the home will seek appropriate support if implemented strategies provided prove to be ineffective
- processes for monitoring that planned interventions for responding to responsive behaviours are implemented by staff and the effect of the intervention is documented
- a process for reassessment, monitoring and re-evaluation of best care strategies

This plan must be submitted in writing to MOHLTC, Attention: Kelly Burns, email kelly.burns@ontario.ca on or before July 25, 2014.

**Grounds / Motifs :**

1. Related to Log # O-001178-13 - For Resident #001:

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(554)

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(554)

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The responsive behaviours exhibited by Resident #001 continue to place the identified resident at risk of harm to self and other residents. (554)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 01, 2014

## 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 8th day of July, 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