Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 27, 2015;	2014_191107_0022 (A1)	H-001215-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE SOUTHWESTERN ONTARIO INC
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE ST. CATHARINES
283 Pelham Road St. Catharines ON L2S 1X7

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

MICHELLE WARRENER (107) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ground #2 was removed from order CO #001 s. 19 - was a duplicate

Issued on this 27 day of February 2015 (A1)

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

Original report signed by the inspector.

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MICHELLE WARRENER (107) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): September 18, 19, 22, 23, 24, 25, 26, October 27, 28, 29, 2014

Follow up inspections related to outstanding orders for H-000099-14 (s. 24(1)) and H-000100-14 (s. 3(1)), and Complaint inspection H-000708-14 were completed during this Resident Quality Inspection. A separate report related to follow up H-000099-14 will be issued at a later date.

During the course of the inspection, the inspector(s) spoke with Residents, family members of residents, Resident and Family Council representatives, The Administrator, Director of Care, nursing staff - Registered Nurse(RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Environmental Manager, environmental, housekeeping, maintenance staff, Dietary Manager (DM), dietary staff, Program Manager, program staff

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

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

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

- **19 WN(s)**
- **7 VPC(s)**
- **3 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 LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A) Resident #015 was not protected from abuse. During Stage one of the RQI process a resident confirmed they were fearful of another resident and they had witnessed an incident of abuse. The nursing progress notes confirmed an incident of abuse occurred. The progress notes also confirmed the Power of Attorney (POA) for the resident who was abused had voiced concerns about the safety of their family member. The resident who was abused complained of pain after the abuse. A review of the clinical records for the abusive resident indicated numerous incidents of responsive behaviours. Interview with the registered staff confirmed the abusive resident was known to have multiple responsive behaviours and that resident #015 was not protected from abuse. (511)

B) The licensee did not ensure that resident #041 was protected from abuse by anyone. Progress notes and staff interviews confirmed that resident #004 was abusive and caused resident #041 to fear for their safety. Resident #004 had numerous documented incidents of abuse.

Progress notes for resident #041 identified the resident was fearful of the other resident. During interview, resident #041 stated that they had been abused and felt afraid of the other resident. The DOC confirmed that the resident on resident altercations had occurred and that resident #041 had been injured and continued to feel afraid.

In both cases the aggressors were known to be abusive and the home did not put strategies in place to protect residents #015 and #041. (526) [s. 19. (1)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents' right to be protected from abuse was fully respected and promoted.

Progress notes and staff interviews confirmed that resident #004 had abused residents #041 and resident #045. Staff interviews indicated that resident #004 was known to exhibit abusive and responsive behaviours.

The Administrator stated that the staff did not intervene with this altercation according to the home's expectations. The Administrator confirmed that the home did not implement interventions to minimize the altercations that resulted in harmful interactions between these residents. (526) [s. 3. (1) 2.]

2. The licensee failed to ensure that resident #009's rights were fully respected and promoted when the resident was not properly cared for in a manner consistent with their needs.

Resident #009's plan of care, that staff referred to for direction in providing resident care, directed the staff to use two staff for transferring the resident to ensure safety.

On a specified date, a staff member proceeded to get the resident up without the assistance of another staff member which resulted in resident #009 falling. The resident sustained injuries due to the fall.

It was confirmed by the Director of Care that resident #009 was not properly cared for in a manner consistent with their needs. (508) [s. 3. (1) 4.]

Additional Required Actions:

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

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 with ensuring that every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A) A review of the clinical records for resident #044 indicated the resident had a history of responsive behaviours and an assessment related to the behaviours had been completed. The assessment report suggested several strategies to help decrease the occurrence of responsive behaviours. Another assessment by a different discipline also recommended different strategies. The MDS quarterly assessment triggered a Psychosocial Well-being RAP which identified the resident had incidences of responsive behaviours. The note indicated the RAP would be care planned with the overall goal of improvement. A review of the resident's written plan of care did not include the interventions or recommendations from the assessment reports or Psychosocial Well-being RAP.
Staff interview confirmed procedures and interventions were not developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of the resident's responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. (511)

B) Progress notes and staff interviews confirmed that resident #004 had abused resident #041 on several identified dates. Staff interviews indicated that resident #004 was known to exhibit responsive behaviours. The key triggers were identified by staff.

According to resident #004's plan of care, staff were directed to provide specific interventions to respond to the behaviours. Registered staff confirmed that the plan of care had not been effective in minimizing the risk of potential altercations between residents. The DOC stated that the home had attempted to better manage altercations between residents by using a specific intervention; however, the residents did not agree to comply with this intervention.

On an identified date, a staff member heard an altercation between residents.

The Administrator stated that the staff did not intervene with the altercation according to the home's expectations. The Administrator confirmed that the home did not implement interventions to minimize the risk of altercations and potentially harmful interactions between residents. (526) [s. 55. (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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. The licensee has failed to ensure that the plan of care for resident #001 set out clear directions to staff and others who provided direct care to the resident. The care plan, that staff referred to for directions related to care provision, did not identify strategies for fall prevention. The interventions were identified in the progress notes; however, were not identified on the resident's care plan. One staff interviewed stated that these strategies were required; however, not all staff were aware of the strategies and the strategies were not in place on an observed day. Direction to staff in relation to the fall prevention strategies was unclear. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A) Resident #009 had been assessed by a specialist on a specified date. Interventions identified in the specialist assessment were identified in the progress notes. The resident's care plan, that staff referred to for directions, did not included all of the identified interventions.

An interview with registered staff confirmed that the care plan did not include all of the interventions based on the specialist's assessment. (508)

B) Resident #031's health record indicated a specific diagnosis. Registered staff confirmed that the resident's plan of care did not include instructions for staff regarding infection prevention measures in the care of resident #031. On September 25, 2014, a PSW who had just completed care for resident #031 stated that they were not aware that contact precautions were required and had not been using Personal Protective Equipment(PPE) as recommended in the home. (526)

C) Resident #036 was identified as being resistive to care which was not easily altered in the Minimum Data Instrument (MDS) coding. A review of the resident's plan of care indicated that it did not include the information from the assessment completed in MDS for the resident's responsive behaviours.

An interview with the registered staff confirmed that the plan of care was not based on the assessment of the resident and the resident's needs and preferences. (508) [s. 6. (2)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident so that their assessments were integrated, consistent with and complemented each other.

A) The Minimum Data Instrument (MDS) coding identified that resident #036 was resistive to care which was not easily altered. The MDS coding changed, where the resident was no longer resistive to care. It was also coded in MDS that there had been no change in the resident when there had been a change.

It was confirmed by registered staff that the assessments did not complement each other. (508)

B) On an identified date, resident #012 stated they had ongoing pain. The resident stated sometimes they could not sleep because of the pain. Interview with the RN confirmed the resident had significant pain. The resident's plan of care identified chronic pain, however, did not identify the location of the pain. Pain assessments and progress notes did not identify any pain. The resident had an order for as needed pain reliever; however, the resident was not administered any pain medication for an identified month. The assessments related to pain were inconsistent. (107) [s. 6. (4) (a)]

4. The licensee has failed to ensure that resident #001 was provided the opportunity to participate fully in the development and implementation of their plan of care. The resident voiced concerns to the inspector that the home was having a meeting about the resident and the resident was not invited to the meeting. The resident stated they were not sure what was being discussed at the meeting and that staff do not involve the resident in their plan of care. Staff confirmed that a care conference was held and stated only the resident's substitute decision maker was invited to the meeting. During interview, the Program Manager confirmed the resident was capable of being involved in care decisions at present. [s. 6. (5)]

5. The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in the plan.

A) Resident #036's plan of care directed staff to provide specific interventions. It was observed on two different dates that resident #036 did not have the required interventions in place.

It was confirmed by staff that they did not provide care to resident #036 as specified in their plan of care. (508)

B) During interview on two identified dates, resident #001 stated they were not offered

a choice of a bath or shower. The resident's plan of care identified the resident preferred a shower. The resident confirmed they preferred a shower but stated that they had to have a bath instead. Staff stated the resident was given a bath and appeared to like it and a bath was continued. A shower was not provided to the resident as per their preference stated on the plan of care. (107) [s. 6. (7)]

6. The licensee has failed to ensure that resident #044 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A review of resident #044's clinical records indicated the resident, on admission, had no pain. The resident had a procedure after admission and review of the physician record indicated a narcotic pain medication was added. A review of the resident's written plan of care did not include the resident's pain, goals or the planned care for pain management for resident #044 after the change in condition. Interview with the DOC confirmed the resident's plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

7. The licensee has failed to ensure that resident #004 was reassessed and the plan of care reviewed and revised at least every six months and when care set out in the plan had not been effective.

Resident #004 was a high risk for falls and was noted to have fallen while transferring on four identified dates. Registered staff confirmed that the plan of care related to falls had not been updated or changed since the resident sustained four falls over a five month period. [s. 6. (10) (c)]

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 with sections 6(2), 6(4)(a), 6(7) and section 6(10)(b), to be implemented voluntarily.

WN #5: 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. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's, "Falls Prevention and Management Program", policy RESI-10-02-01, last reviewed on April 2013, directed staff to "complete the following ongoing assessment of the resident for a minimum of 72 hours after each fall: Each shift the resident is to be assessed for i) pain; ii) bruising; iii) change in functional status; iv) change in cognitive status; and v) changes in range of motion". The policy also directed staff to document all assessments and actions taken during the 72 hour post fall follow-up in the progress notes. Registered staff confirmed that post falls documentation was only located in the progress notes.

A) Progress notes indicated that resident #004 fell while self transferring. Progress notes indicated that not all assessment areas were documented each shift for 72 hours after the resident's fall as per the home's policy. Registered staff confirmed that post falls documentation was not completed according to the home's policy. (526)

B) Resident #009 had a fall and sustained injuries. A review of the resident's clinical record indicated that staff did not follow the Falls Prevention and Management Program for post fall assessments and documentation. The 72 hour post fall follow-up assessments and documentation for resident #009 did not consistently include pain, bruising, change in functional and cognitive status, and changes in range of motion. (508)

C) Resident #001 sustained numerous falls and/or injuries over a three month period. A review of the resident's clinical record indicated that staff did not follow the Falls Prevention and Management Program for post fall assessments and documentation. The 72 hour post fall follow-up documentation in the progress notes for resident #001 did not consistently include pain, bruising, change in functional and cognitive status, and changes in range of motion. (107) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily used by residents, staff and visitors at all times.

It was identified during this inspection on September 19 and September 22, 2014, in rooms 100, 223, and 226, that the residents' call bell cords in their bathrooms would detach when pulled which did not activate the call bell system. The call bell cord in room 100 had a black plastic zip tie attaching the call bell cord to the metal plate on the wall, however, the cord was not attached to the device that would activate the call bell system.

It was confirmed by the maintenance staff that the communication and response system in rooms 100, 223, 226 were not easily used by residents, staff and visitors. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the home was equipped with a resident-staff communication and response system that could be easily used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's "Resident Abuse by Persons Other Than Staff", Policy number 02-02-04, dated November 2013, directed all persons in the home responding/ reporting suspected or witnessed abuse to immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care, or their designate, and as required by provincial legislation, to the MOHLTC Director through the Critical Incident Reporting System. The policy makes note that staff failure to immediately report, verbally, the incident to the Administrator, Director of Care or their designate could receive disciplinary action. The policy #Oper-02-02-04 also directed the Administrator/Director of Care/Designate of the home, upon notification of the alleged abuse, to initiate an internal investigation and complete a preliminary report before going off duty and to ensure comprehensive of all investigative documentation. The policy referred to the required documentation section within the policy as set out below.
Required documentation as outlined in the policy:
-Resident Incident Report
-Investigative Notes (Document pertinent details of the investigation, actions taken during the investigation and any actions taken as a result of the outcome of the investigation and kept in a secured location)

A) Interview with the DOC and Administrator on October 27, 2014 confirmed the process for reporting witnessed or alleged abuse would include a call from the registered staff to the on call phone if the allegation occurred after hours and directly to the DOC or Administrator during working hours (0900-1700hours). The DOC and Administrator confirmed the Resident Incident report, as directed in the policy, would be completed by the registered staff through the Point Click Care (PCC) system and would be referred to as the Risk Management report. The DOC stated she would then review the 24 hour report, the next business day, as part of the daily management meeting, complete a MOHLTC Critical Incident (CI) report and initiate an internal investigation. Both the Administrator and DOC confirmed they would open an investigation file that would include a review of the progress notes, the completed CI as well as any documented interviews with applicable staff and residents as required. The DOC and Administrator confirmed they could not recall being notified verbally by the registered staff the evening of the witnessed resident to resident altercation incidents, confirmed there were no CI's completed and there were no comprehensive

investigative files/notes for resident #044 or #200 for incidents that occurred on two specified dates. (511)

B) Progress notes indicated that resident #004 had abused residents in the home on three identified dates. A review of all the Critical Incidents submitted by the home indicated that the home had not reported these incidents of abuse to the Director according to the home's policy. The Director of Care (DOC) confirmed this to be true. The Administrator stated that they did not know why Critical Incidents weren't submitted to the Director for the abuse incidents that occurred on the three identified dates. (526) [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

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:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination. Staff confirmed the resident had a change in continence and elimination patterns. The resident was independent with toileting prior to the change. After the change in condition, the resident required full assistance with toileting; however, staff stated the resident was also refusing to be toileted for bowel and bladder elimination. A Personal Support Worker (PSW) providing care to the resident stated staff were using specific interventions on the day shift; however, this was not on the incontinence forms or the resident's plan of care and staff stated that there weren't enough products for the PSW to use for the evening shift. A different intervention was being used for the evening shift. The PSW was concerned some of the interventions were not meeting the resident's needs. The Registered Nurse (RN) stated both a bowel and bladder continence assessment (on Point Click Care) was to be completed upon return from hospital and change in condition. The RN confirmed the bowel and bladder assessment forms were not completed after the change in condition. The resident's plan of care did not identify the strategies being used by staff related to continence. The Kardex provided no direction to staff providing direct care to the resident related to toileting or continence. [s. 26. (3) 8.]

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 with ensuring a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: continence, including bladder and bowel elimination, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #009.

Resident #009's plan of care, that staff referred to for direction in providing resident care, directed staff to transfer the resident with two staff. On a specified date a staff member proceeded to get the resident up without assistance of another staff member which resulted in resident #009 falling. The resident sustained injuries due to the fall.

It was confirmed by the Director of Care that the staff member did not use safe transferring techniques when assisting resident #009. (508) [s. 36.]

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 with ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules were complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On the initial tour of the home on September 18, 2014, a door to an electrical fire panel room on the first floor was left unlocked and unsupervised. The door had signage stating 'authorized personal only'. Residents were observed to be wandering about the unit and had access to this room. Interview with maintenance personnel confirmed the door was unlocked, unsupervised and should have been locked when not supervised to ensure the residents did not have access. [s. 9. (1) 2.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, were documented.

A) Resident #009 had a fall on a specified date. An interview with the Director of Care (DOC) indicated that after the resident fell, the resident was assessed by the physician who was in the building at the time of the incident. The resident was then transferred to the hospital for further assessments.
The resident's post fall nursing assessment had been documented and a pain assessment. The documentation that followed indicated the resident returned from hospital. Between the time of the pain assessment and the resident's return from hospital staff did not document any re-assessments and did not indicate that the resident had been transferred out to hospital for further assessment.

A review of the resident's clinical records indicated that the assessments and the interventions described by the DOC had not been documented.

B) A review of resident #036's clinical record indicated that the resident had specific symptoms of a condition. An interview with the Registered Nurse (RN) indicated that the resident was monitored after the initial symptom. The RN stated that staff had consulted with the physician and was advised to continue to monitor the resident and provide specific interventions if required. The consult and the monitoring of the resident's symptoms over a two day period had not been documented.

It was confirmed by the RN that staff did not document the monitoring of resident #036's symptoms including their assessments until days later when the symptoms had resolved.(508)

C) Resident #005 had an Interdisciplinary Team Conference (IDTC). The documentation was incomplete in several areas of the form and did not identify who attended the meeting. The document had not been signed as completed and remained, "in progress". Registered staff confirmed the document was incomplete and they were unable to identify if the resident had attended the IDTC meeting by reviewing the documentation. (107)

D) An IDTC meeting for resident #001 was held on a specified date. The resident stated they had not been invited to attend the conference. The document remained "in progress" and was incomplete in many of the areas on the form, including who attended the meeting. (107) [s. 30. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents received individualized personal care, including hygiene care and grooming on a daily basis.

During the Stage one observation period from September 18, 19, 22, 2014 resident #030, #042, #043, and #001 where observed to have long facial hair. Interview with the four PSW's that provided care to these residents on September 23 and 24, 2014 confirmed the residents' personal hygiene for removal of facial hair had not been completed. A review of the home's Resident care manual identified by Document number RESI-05-07-05 subject: Facial grooming /cosmetics confirmed "residents will be assisted as required to remove facial hair to increase self esteem and present a well groomed appearance". Interview with the DOC confirmed the residents did not receive individualized personal care that included facial grooming on a daily basis. (107) [s. 32.]

WN #13: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an annual resident satisfaction evaluation of continence care products was completed in consultation with residents, substitute decision-makers (SDM) and direct care staff. Staff confirmed a resident/SDM annual satisfaction evaluation of continence care products was not completed for 2013. [s. 51. (1) 5.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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. The licensee has not ensured that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A review of resident #044's clinical records indicated the resident had been receiving occasional medication as needed for pain. The resident had one pain assessment on admission which indicated no pain. The physician later ordered a narcotic pain medication as needed for pain. A review of the electronic medical record confirmed the resident had increasing use of the narcotic medication from seven doses one month, five doses the next month, seven doses the subsequent month, 29 doses the next month, 20 doses the next month, 27 does the subsequent month, 35 doses the next month and 33 doses in the next month. This was in addition to the continued occasional administration of as needed pain medication. The clinical records did not indicate pain was assessed using a clinically appropriate assessment instrument since admission. Interview with the RAI coordinator confirmed a MDS pain assessment should have been completed and was not completed when the resident's pain was not relieved. [s. 52. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours were developed to meet the needs of residents with responsive behaviours, including resident #036.

It was identified on the resident's plan of care that resident #036 had responsive behaviours. The interventions on the care plan that staff referred to for direction, directed staff to:

1. Identify the root cause of the behaviour and develop strategies/alternate approaches to address

2. Monitor the resident's behaviour episodes and attempt to determine underlying causes. Consider location, time of day, situation.

During an interview with Personal Support Workers (PSW) triggers were identified for the behaviours. Staff identified strategies they would use to manage the behaviours. The resident's plan of care did not include these specific strategies or interventions.

An interview with staff confirmed that the resident's plan of care did not include written strategies, including techniques and interventions, to prevent, minimize or respond to resident #036's responsive behaviours. [s. 53. (1) 2.]

2. The licensee has failed to ensure that, for all programs and services, the matters referred to in subsection (1) were a) integrated into the care that was provided to resident #004; b) based on the assessed needs of resident #004 who had responsive behaviours; and c) co-ordinated and implemented on an interdisciplinary basis.

Progress notes and staff interviews confirmed that resident #004 was known to have responsive behaviours.

i) Review of resident #004's health record and interview with registered staff indicated that the resident had not received an in-depth assessment according to the home's policy on Responsive Behaviours, number 09-05-01, dated September 2010, even though the resident continued to exhibit responsive behaviours.

ii) Progress notes indicated that resident #004 was referred to an outside agency related to behaviours. The DOC confirmed that the home had not obtained the consultant's notes eight months after the consultation had occurred. The home failed to follow up and obtain the recommendations from the consultation. Any strategies proposed in the consultation were unknown to the staff and unable to be implemented.

iii) Progress notes indicated that a physician provided specific instruction related to resident #004's behaviours and referral to other resources. Progress notes and registered staff interviews confirmed that staff did not follow the physician's instructions. During interview registered staff confirmed that a referral of resident #004 to specialized resources where required was not implemented. [s. 53. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During the course of this inspection, it was identified that there was a lingering urine odour in the resident corridors. On September 24, 2014, the Inspector identified that in an identified room, and a resident's bathroom shared by four residents, had a strong lingering urine odour which was confirmed by a Personal Support Worker (PSW) on the unit.

On September 25, 2014, during a tour with the Environmental Manager, it was identified that three mattresses in the identified room had urine odours which were observed to be throughout the layers of the mattresses. An unidentified offensive odour was observed in the room beside one of the residents' bed. The urine odour was also identified in the corridor outside two identified rooms.

It was confirmed by the Environmental Manager that there were lingering odours in these identified areas. [s. 87. (2) (d)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any witnessed incident of abuse of a resident that the licensee suspected may have constituted a criminal offense.

A review of the clinical records for resident #015 did not indicate the police were notified when a co-resident was observed to become physically abusive towards the resident. The Administrator confirmed the home's direction that if the home suspected a criminal offense had taken place and provided the examples of theft, sexual or physical assault, the home was to contact the police immediately. The Administrator confirmed the police had not been contacted. [s. 98.]

WN #18: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included:

(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

Progress notes and staff interviews confirmed that resident #041 was abused by resident #004 on multiple identified dates. During interview, resident #041 stated that they had complained to staff and the home's Director of Care (DOC) that resident #004 had abused the resident, and that they were afraid that resident #004 would continue to be abusive. The resident felt that the issue had not been resolved.

An interview with the Administrator indicated that the Administrator spoke with resident #041 after each incident of abuse and felt that the issue had been resolved within 24 hours, and so did not document the complaint. However, the Administrator could not provide documentation of the resident's unresolved complaints about being abused by resident #004 on an identified date. Specifically, a record was not kept in the home that included the nature of resident #041's complaints, the date the complaints were received, the type of action taken to resolve the complaints, the final resolutions, or response dates. [s. 101. (2)]

WN #19: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the home's infection prevention control program. The home's Infection Prevention and Control Policy included Routine/Standard Precaution Practices number INFE-02-01-01 dated January 2013.

A) The policy directed care staff to follow all PPE (Personal Protective Equipment) instructions as outlined on the resident's door. On September 25, 2014, Long Term Care Homes Inspector observed a Personal Support Worker (PSW) exiting an identified resident room that had a sign posted on the door indicating that contact precautions were to be used with a resident living in that room. When asked, the PSW stated that they had just completed care for the resident and was not aware that contact precautions were required. Registered staff confirmed that staff were to use contact precautions when working with the resident. (526)

B) On September 25, 2014, at approximately 1100 hours, it was observed by the inspector in a resident's bathroom shared by four residents, that a facecloth soiled with feces was sitting on the resident's sink. Incontinence care had been provided to the residents earlier that morning and the cloth had been left on the sink from that time.

The Environmental Manager confirmed that the facecloth had been soiled with feces and immediately removed it from the resident's sink. [s. 229. (4)]

Issued on this 27 day of February 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MICHELLE WARRENER (107) - (A1)

Inspection No. / No de l'inspection : 2014_191107_0022 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-001215-14 (A1)

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

Report Date(s) / Date(s) du Rapport : Feb 27, 2015;(A1)

Licensee / Titulaire de permis : EXTENDICARE SOUTHWESTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD : EXTENDICARE ST. CATHARINES
283 Pelham Road, St. Catharines, ON, L2S-1X7

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : JANE FREEMAN

To EXTENDICARE SOUTHWESTERN 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee shall protect residents, including residents #041 and #015, from abuse by anyone. The licensee shall:
A) Assess residents #044 and #004 in relation to responsive behaviours, develop strategies to manage the behaviours, and ensure the residents plans of care are updated as a result of the assessments and developed strategies.
B) Develop a procedure for internal communication related to suspected or actual incidents of abuse. The procedure shall ensure that incidents of suspected or actual abuse will be identified, investigated, and reported to the Director as per legislative requirements.
C) Review and educate all staff on the home s abuse policy and definitions of abuse.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A) Resident #015 was not protected from abuse. During Stage one of the RQI process a resident confirmed they were fearful of another resident and they had witnessed an incident of abuse. The nursing progress notes confirmed an incident of abuse occurred. The progress notes also confirmed the Power of Attorney (POA) for the resident who was abused had voiced concerns about the safety of their family member. The resident who was abused complained of pain after the abuse. A review of the clinical records for the abusive resident indicated numerous incidents of responsive behaviours. Interview with the registered staff confirmed the abusive resident was known to have multiple responsive behaviours and that resident #015 was not protected from abuse. (511)

B) The licensee did not ensure that resident #041 was protected from abuse by anyone. Progress notes and staff interviews confirmed that resident #004 was abusive and caused resident #041 to fear for their safety. Resident #004 had numerous documented incidents of abuse.

Progress notes for resident #041 identified the resident was fearful of the other resident. During interview, resident #041 stated that they had been abused and felt afraid of the other resident. The DOC confirmed that the resident on resident altercations had occurred and that resident #041 had been injured and continued to feel afraid.

In both cases the aggressors were known to be abusive and the home did not put strategies in place to protect residents #015 and #041. (526) [s. 19. (1)] (526)

(A1)
Ground #2 has been removed.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Jun 01, 2015

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2013_250511_0007, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that residents, including resident #041, are protected from abuse.
The licensee shall:
1. Assess resident #004 in relation to responsive behaviours.
2. Implement interventions to mitigate risks for other residents in relation to resident #004.
3. Update the plan of care for resident #004 to include the information identified in the assessment and the interventions to mitigate risks to other residents.
4. Provide education to Registered and non-registered staff in relation to prevention of abuse and neglect, and the home's policies regarding responsive behaviours and prevention of abuse and neglect.

Grounds / Motifs :

1. The licensee failed to ensure that residents' right to be protected from abuse was fully respected and promoted.

Progress notes and staff interviews confirmed that resident #004 had abused residents #041 and resident #045. Staff interviews indicated that resident #004 was known to exhibit abusive and responsive behaviours.

The Administrator stated that the staff did not intervene with this altercation according to the home's expectations. The Administrator confirmed that the home did not implement interventions to minimize the altercations that resulted in harmful interactions between these residents. (526) [s. 3. (1) 2.] (107)

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

Jun 01, 2015

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee shall:
1. Re-assess residents #004 and #044 in relation to responsive behaviours.
2. Implement interventions to mitigate risks for other residents in relation to residents #004 and #044.
3. Update the plans of care for residents #004 and #044 to include the information identified in the assessments and the interventions to mitigate risks to other residents.
4. Provide education to Registered and non-registered staff in relation to responsive behaviours, abuse, and the home's policies regarding responsive behaviours and prevention of abuse and neglect.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A) A review of the clinical records for resident #044 indicated the resident had a history of responsive behaviours and an assessment related to the behaviours had been completed. The assessment report suggested several strategies to help decrease the occurrence of responsive behaviours. Another assessment by a different discipline also recommended different strategies. The MDS quarterly assessment triggered a Psychosocial Well-being RAP which identified the resident had incidences of responsive behaviours. The note indicated the RAP would be care planned with the overall goal of improvement. A review of the resident's written plan of care did not include the interventions or recommendations from the assessment reports or Psychosocial Well-being RAP.
Staff interview confirmed procedures and interventions were not developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of the resident's responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. (511)

B) Progress notes and staff interviews confirmed that resident #004 had abused resident #041 on several identified dates. Staff interviews indicated that resident #004 was known to exhibit responsive behaviours. The key triggers were identified by staff.

According to resident #004's plan of care, staff were directed to provide specific interventions to respond to the behaviours. Registered staff confirmed that the plan of care had not been effective in minimizing the risk of potential altercations between residents. The DOC stated that the home had attempted to better manage altercations between residents by using a specific intervention; however, the residents did not agree to comply with this intervention.

On an identified date, a staff member heard an altercation between residents.

The Administrator stated that the staff did not intervene with the altercation according to the home's expectations. The Administrator confirmed that the home did not implement interventions to minimize the risk of altercations and potentially harmful interactions between residents. (526) [s. 55. (a)] (526)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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

Jun 01, 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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Director
c/o Appeals Coordinator
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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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

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

Directeur
a/s Coordinateur des appels
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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 27 day of February 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MICHELLE WARRENER - (A1)

Service Area Office /
Bureau régional de services : Hamilton