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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 28, 2016	2016_30610a_0019	024103-16	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

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

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

IRENE SCHMIDT (510a), KELLY CHUCKRY (611), KERRY ABBOTT (631), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 6, 7, 8, 9, 13, 14, 15, 16, 19, 20, 21, and 22, 2016.

In addition to the Risk focused RQI, the following inspections were completed:
1. Six follow ups, including #002822-16 (s.55), #002823-16 (s. 8(1)(b)), #002828-16 (s. 6(1)(c)), #002829-16 (s. 6(7)), #002830-16 (s. 6(10)(b)), and #002831-16 (s. 6(10)(c)).
2. Six on site inquiries, five related to responsive behaviors including #005690-14, #006758-14, #006889-14, #009246-14, and 011665-15, and one related to a fall, #000321-15.
3. Thirteen critical incidents including #002139-14 (responsive behaviors), #003187-14 (responsive behaviors), #000082-15 (responsive behavior), #004227-15 (resident to resident altercation), #009304-15 (fall with fracture), #023223-15 (responsive behavior), #026793-15 (resident to resident altercation), #028120-15 (resident to altercation), #004238-16 (staff to resident verbal abuse), #005221-16 (responsive behaviors), #015113-16 (resident to resident altercation), #020958-16 (falls), and
4. Three complaints, including #013189-16 (resident to resident altercation), #020032-16 (falls) and #027128-16 (pain, reporting, falls, notification of POA, neglect)

During the course of the inspection, the inspector(s) spoke with residents, families, registered nurses (RN's), registered practical nurses (RPN's), personal support workers (PSW's), Resident Programme Manager (RPM), Resident Assessment Inventory (RAI) Coordinator, Physiotherapist (PT), Director of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

- **7 WN(s)**
- **4 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 55.	CO #001	2015_247508_0014	510a
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #003	2015_247508_0014	510a 611 631 632
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #005	2015_247508_0014	510a 611 631 632
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #006	2015_247508_0014	510a 611 631 632
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #004	2015_247508_0014	510a 611 631 632
O.Reg 79/10 s. 8. (1)	CO #002	2015_247508_0014	510a

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.O. 2007, c.8, 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 their written policy that promotes zero tolerance of abuse and neglect of residents, was complied with.

The home had a policy in place entitled Resident Abuse, By Persons Other Than Staff (OPER-02-02-04). This policy outlined how to respond to any form of alleged, potential, suspected or witnessed, abuse. This included that the Ministry of Health and Long Term Care (MOHLTC) was to be contacted about any such incident. It further specified that disclosure of the alleged abuse would be made to the substitute decision maker (SDM) immediately upon becoming aware of the incident, and that emotional support would be provided for the resident. It was also an expectation of the home that when an incident of this nature occurred, documentation would be completed in the clinical health record.
Resident #505 was admitted to the home with an identified diagnosis. Shortly after admission, this resident began exhibiting responsive behaviors.
Resident #506 lived in the same home area as resident #505. On an identified date, resident #506 rang the call bell for assistance. Resident #505 was witnessed by staff to be interacting inappropriately with resident #506. This incident was not reported to the MOHLTC and was not documented in the clinical health record for resident #506. This incident was not disclosed to the SDM for resident #506 and there was no evidence that this resident was offered other specialized supports after the incident.
An interview with staff #111 confirmed that the noted policy was not followed with respect to the incident that occurred on the identified date.
The Director of Care (DOC) and Resident Program Manager (RPM) confirmed that the home did not comply with the above noted policy and expectations of the home. [s. 20. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 all residents were protected from abuse by anyone in the home.

Resident #505 was admitted to the home with an identified diagnosis. Shortly after admission, this resident began exhibiting responsive behaviors. During an identified time period, resident #505 had an identified intervention in place to mitigate the risk towards any resident in the home. This identified intervention was to be in place sixteen hours daily and was subsequently increased to twenty-four (24) hours a day.
Resident #506 lived in the same home area as resident #505. On an identified date, resident #506 was ringing the call bell for assistance. Resident #505 was witnessed by staff, to be interacting inappropriately with resident #506. A specified intervention was to be in place at the time of this incident. Record review revealed that the specified intervention was not in place at the time of the incident.
On another identified date, resident #505 was again witnessed by staff interacting inappropriately with resident #506. During this incident, it was documented in the clinical health record that resident #506 was very upset and calling out for help. The specified intervention was to have been implemented at the time of this incident, and was not.
A further review of the clinical health record for resident #505 for an identified 16 week period, was conducted. During this time period there were a total of five (5) other occasions where the specified intervention was to be in place, and was not.
An interview conducted with staff #109 verified that when the specified intervention was in place, the resident was not always supervised. The DOC confirmed that it is the homes expectation that when a resident has the specified intervention in place, the resident would be supervised, at all times.
The Director of Care (DOC) and Resident Program Manager (RPM) confirmed that the specified intervention was not always in place for resident #505 and further confirmed the home did not protect resident #506 from abuse. [s. 19. (1)]

Additional Required Actions:

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

WN #3: 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 failed to ensure 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 the clinical record for resident #006 indicated that the resident sustained an injury related to an incident in the home. The injury required surgical intervention and the resident was discharged from the hospital, to the home. A review of the resident's Electronic Medication Administration Record (eMAR) indicated that for the six months prior to the incident, the resident's pain was managed with an order for analgesic medication. During this period of time, the resident was administered this medication between one and six times each month. The record indicated that after the incident and subsequent discharge from hospital, the resident was ordered another analgesic medication for a limited period of time, as well as the medication that had been previously ordered. The eMAR indicated that after the other analgesic medication was discontinued, the resident requested forty-eight doses of the continuing analgesic medication for an identified four week period. For the next four weeks, the resident requested forty-four doses of the continuing analgesic medication and for the following two weeks the resident requested twenty-three doses of the continuing analgesic. The record indicated that for an identified eight month period, no clinically appropriate Pain Assessment Tool was completed for the resident when there was an increase in frequency of the administration of pain medication, nor was the effectiveness of the pain medication consistently evaluated.
A review of the resident's minimum data set (MDS) assessments showed an assessment was completed due to a significant change in status, on a specified date. The record indicated that under section 'J' (pain), under frequency, the resident experienced pain daily and under intensity, there were times that pain was horrible or excruciating.
An interview with the resident confirmed that their pain was often excruciating and that the continuing analgesic they were provided, was not effective to manage their pain. The resident further stated that they felt they shouldn't have to ask for pain medication and

that the only medication that controlled their pain was the analgesic that had been ordered for a limited time, after the fall.
An interview with the Resident Assessment Instrument (RAI) Co-ordinator confirmed that the expectation when administering pain medication, was that the effectiveness of the pain medication be documented and a pain assessment be completed, if there was increased frequency of requests for pain medication.
An interview with registered staff #104 confirmed that there were no pain assessments completed for this resident related to the increased frequency of the continuing analgesic order. Staff stated that the process was, that when a resident requested pain medication, a numeric score between 0 and 10 was entered into the eMar. Staff confirmed that the Pain Assessments that were opened under the assessment tab were not completed and were titled inactive. Staff confirmed that no assessment tool was currently being utilized to monitor the resident's description, location, or provoking factors of pain. [s. 52. (2)]

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.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

A review of resident #006 clinical record indicated that on an identified date, the resident sustained an injury as a result of an incident in the home. According to the record, appropriate signage to caution residents, staff and visitors of a hazard, was not put in place when a hazard was known to exist. As a result, the resident sustained an injury which required surgical intervention. The record also indicated the home initiated an investigation after the incident which confirmed signage of an identified hazard was not put in place to caution residents, staff and visitors.
An interview with resident #006 was conducted, and the resident reported they did not notice the hazard, in the absence of signage, which resulted in the incident and injury.
An interview with the Administrator confirmed that appropriate signage was not used to identify a hazard and that it was the home's expectation that such signage be used. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home is a safe and secure environment for residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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 care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #509 had a history of responsive behaviors. A review of resident #509's care plan indicated that during a specified time frame, an intervention for responsive behaviors was in place for eight hours daily, and at a subsequent time, was in place, without interruption.
On four identified dates, resident #509 demonstrated inappropriate interactions with four identified residents, at times when the specified intervention was to have been in place.
An interview conducted with staff #109 verified that when the intervention was to be in place, the resident was not always supervised. The DOC confirmed that it was the homes expectation that when the specified intervention was in place, the resident would be supervised, at all times.
An interview conducted with the Administrator and Education Coordinator confirmed that for each of the four incidents, the intervention should have been in place for resident #509. It was further confirmed that care was not provided for resident #509 as specified in the plan.

B) Resident #505 was admitted to the home with an identified diagnosis. Shortly after admission, this resident began exhibiting responsive behaviors. From an identified date, resident #505 had an identified intervention in place to mitigate the risk of inappropriate behavior towards any resident in the home. Review of the care plan for resident #505 for the identified time period, indicated that the intervention was to be provided to the resident.

On five identified dates, it was documented in the clinical record that resident #505 was not supervised when the identified intervention should have been in place.
An interview conducted with staff #109 verified that when an identified intervention was in place, the resident was not always supervised.
The DOC confirmed that it was the homes expectation that when the identified intervention was in place, the resident would be supervised at all times.
The DOC and the RPM confirmed that, in the above incidents for resident #505, the care set out in the plan of care was not provided to this resident as specified in the plan. [s. 6. (7)]

2. The licensee had failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time, when the resident's care needs changed or care set out in the plan was no longer necessary. s.6 (10)b

A) A review of the written plan of care for resident #017 on an identified date, contained information about the activities of daily living (ADL) support identifying that this resident required supervision-set up for eating. A review of the Minimum Data Set (MDS) on an earlier identified date, contained information about the ADL support provided to the resident, which was coded as one person physical assist. On a subsequent identified date, an interview conducted with registered staff #102 confirmed that resident #017 required one person physical assistance with eating, and the plan of care was not reviewed and revised in terms of ADL for eating.
B) A review of the written plan of care for resident #202 on an identified date, contained information about the ADL support for bed mobility identifying that this resident required extensive assistance with one staff. A review of the MDS on an earlier identified date, contained information about the ADL support provided for bed mobility and the resident was coded as extensive assistance two person physical assist. On a subsequent identified date, an interview was conducted with Resident Assessment Inventory (RAI)-MDS Coordinator who confirmed that the resident required two person physical assist and the plan of care was not reviewed and revised in terms of bed mobility.
C) A review of the written care plan for resident #202 contained information about the ADL support for toilet use, identifying that this resident required extensive assistance with one staff for transfer on to toilet. A review of the MDS on an identified date, contained information about the ADL support provided to the resident, which was coded as extensive assistance two person physical assist. On a later identified date, an interview was conducted with RAI-MDS Coordinator, who confirmed that the resident required two person physical assist, and the plan of care was not reviewed and revised in terms of

toilet use. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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, b) is complied with.

The homes policy #RESI-05-02-05, version September 2014, and titled Food and Fluid Intake monitoring, directed that if a resident consumed less than their minimum fluid target levels for three consecutive days, the resident required a hydration assessment and that the hydration assessment must be documented. The policy also directed that a referral to a registered dietician be sent if the resident consumed 50% or less from all meals for three or more days.
Progress notes on an identified date, from the Registered Dietitian (RD), reported a daily fluid intake requirement for resident #407. Review of the clinical record documentation revealed the total fluid intake for resident #407, for an identified seven day period, was below the required fluid intake. There was no hydration assessment documented in the resident's clinical record. As well, for an identified eight day period, average intake for this resident was less than 50% from all meals and a referral was not made to the dietician until day eight, five days late. The above was confirmed by the Administrator. The home did not comply with the policy. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #7: 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 are documented. O. Reg. 79/10, s. 30 (2).

A specified critical incident report, submitted to the Director on an identified date, reported an incident involving staff interaction with resident #404 and resident #405. The Administrator confirmed that the home's investigation verified the incident occurred. Review of the clinical records for resident #404 and resident #405, revealed the absence of documentation regarding the alleged incident, associated assessments, interventions or reassessments. This was confirmed by the DOC and the Administrator. Actions taken with respect to the residents, including assessments, reassessments, interventions and the resident's responses to interventions, were not documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure 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, to be implemented voluntarily.

Issued on this 14th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	IRENE SCHMIDT (510a), KELLY CHUCKRY (611), KERRY ABBOTT (631), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2016_30610a_0019
Log No. / Registre no:	024103-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 28, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE ST. CATHARINES 283 Pelham Road, St. Catharines, ON, L2S-1X7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Freeman

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that their written policy that promotes zero tolerance of abuse and neglect of residents, is complied with, through the retraining of all staff regarding this policy, specifically as it relates to reporting to the Director, notification of the SDM, providing emotional support for the resident and documentation for all of these dimensions of care.

Grounds / Motifs :

1.
The home had a policy in place entitled Resident Abuse, By Persons Other Than Staff (OPER-02-02-04). This policy outlined how to respond to any form of alleged, potential, suspected or witnessed, abuse. This included that the Ministry of Health and Long Term Care (MOHLTC) was to be contacted about any such incident. It further specified that disclosure of the alleged abuse would be made to the substitute decision maker (SDM) immediately upon becoming aware of the incident, and that emotional support would be provided for the resident. It was also an expectation of the home that when an incident of this nature occurred, documentation would be completed in the clinical health record.
Resident #505 was admitted to the home with an identified diagnosis. Shortly after admission, this resident began exhibiting responsive behaviors.
Resident #506 lived in the same home area as resident #505. On an identified date, resident #506 rang the call bell for assistance. Resident #505 was witnessed by staff to be interacting inappropriately with resident #506. This incident was not reported to the MOHLTC and was not documented in the clinical health record for resident #506. This incident was not disclosed to the SDM for resident #506 and there was no evidence that this resident was offered other specialized supports after the incident.
An interview with staff #111 confirmed that the noted policy was not followed with respect to the incident that occurred on the identified date.
The Director of Care (DOC) and Resident Program Manager (RPM) confirmed that the home did not comply with the above noted policy and expectations of the home. [s. 20. (1)] (611)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 :

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from emotional abuse by anyone. The plan shall include
a) strategies to prevent emotional abuse by staff towards any resident,
b) staff education on abuse and responsive behaviours including dates that the education will be completed and
c) staff education on expectations related to one to one staff supervision of all residents who require this intervention, and to ensure that if this intervention is required, that it is provided to residents at all time and without interruptions

Grounds / Motifs :

1. Resident #505 was admitted to the home with an identified diagnosis. Shortly after admission, this resident began exhibiting responsive behaviors. During an identified time period, resident #505 had an identified intervention in place to mitigate the risk towards any resident in the home. This identified intervention was to be in place sixteen hours daily and was subsequently increased to twenty-four (24) hours a day.
Resident #506 lived in the same home area as resident #505. On an identified date, resident #506 was ringing the call bell for assistance. Resident #505 was witnessed by staff to be interacting inappropriately with resident #506. A specified intervention was to be in place at the time of this incident. Record review revealed that the specified intervention was not in place at the time of the incident.
On another identified date, resident #505 was again witnessed by staff interacting inappropriately with resident #506. During this incident, it was documented in the clinical health record that resident #506 was very upset and calling out for help. The specified intervention was to have een implemented at the time of this incident, and was not.
A further review of the clinical health record for resident #505 for an identified 16 week period, was conducted. During this time period there were a total of five (5) other occasions where the specified intervention was to be in place, and was not.
An interview conducted with staff #109 verified that when the specified intervention was in place, the resident was not always supervised. The DOC confirmed that it is the homes expectation that when a resident had the specified intervention in place, the resident would be supervised, at all times.
The Director of Care (DOC) and Resident Program Manager (RPM) confirmed that the specified intervention was not always in place for resident #505 and further confirmed the home did not protect resident #506 from abuse. [s. 19. (1)]

(611)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

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. 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).

Order / Ordre :

The licensee shall provide pain management education for all registered staff, reviewing all aspects of pain management, including use of the clinically appropriate assessment instrument for assessment, planning, implementation of interventions and reassessment of the effectiveness of the interventions.

Grounds / Motifs :

1. A review of the clinical record for resident #006 indicated that the resident sustained an injury related to an incident in the home. The injury required surgical intervention and the resident was discharged from the hospital, to the home. A review of the resident's Electronic Medication Administration Record (eMAR) indicated that for the six months prior to the incident, the resident's pain was managed with an order for analgesic medication. During this period of time, the resident was administered this medication between one and six times, each month. The record indicated that after the injury and subsequent discharge from hospital, the resident was ordered another analgesic medication for a limited period of time, as well as the medication that had been previously ordered. The eMAR indicated that after the other analgesic medication was discontinued, the resident requested forty-eight doses of the continuing analgesic medication for an identified four week period. For the next four weeks, the resident requested forty-four doses of the continuing analgesic medication and for the following two weeks the resident requested twenty-three doses of the continuing analgesic. The record indicated that for an identified eight month period, no clinically appropriate Pain Assessment Tool was completed for the resident when there was an increase in frequency of the administration of pain medication, nor was the effectiveness of the pain medication consistently evaluated.
A review of the resident's minimum data set (MDS) assessments showed an

assessment was completed due to a significant change in status, on a specified date. The record indicated that under section 'J' (pain), under frequency, the resident experienced pain daily and under intensity, there were times that pain was horrible or excruciating.
An interview with the resident confirmed that their pain was often excruciating and that the continuing analgesic they were provided, was not effective to manage their pain. The resident further stated that they felt they shouldn't have to ask for pain medication and that the only medication that controlled their pain was the analgesic that had been ordered for a limited time, after the surgical intervention.
An interview with the Resident Assessment Instrument (RAI) Co-ordinator confirmed that the expectation when administering pain medication, was that the effectiveness of the pain medication be documented and a pain assessment be completed, if there was increased frequency of requests for pain medication.
An interview with registered staff #104 confirmed that there were no pain assessments completed for this resident related to the increased frequency of the continuing analgesic order. Staff stated that the process was, that when a resident requested pain medication, a numeric score between 0 and 10 was entered into the eMar. Staff confirmed that the Pain Assessments that were opened under the assessment tab were not completed and were titled inactive. Staff confirmed that no assessment tool was currently being utilized to monitor the resident's description, location, or provoking factors of pain. [s. 52. (2)] (631)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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
Inspection de soins de longue durée
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 28th day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Irene Schmidt

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