Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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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
May 22, 2014	2014_288549_0021	O-000140,O-000297,O-000380-14	Critical Incident System

Licensee/Titulaire de permis

NEW ORCHARD LODGE LIMITED
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE WEST END VILLA
2179 ELMIRA DRIVE, OTTAWA, ON, K2C-3S1

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

RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 28, 29, 30, May 1 and 2, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, Registered Nurses (RN), Registered Practical Nurses(RPN), Personal Support Workers (PSW)and several Residents.

During the course of the inspection, the inspector(s) reviewed resident health care records, resident written care plans, Critical Incident Reports, Resident Abuse- by Persons Other Than Staff policy # OPER-02-02-14 (November 2013 version), the hand out provided to staff at the Education Fair titled Abuse Prevention In Long Term Care, Staff Education Passport for mandatory annual training, Responsive Behaviours policy # 09-05-01 (Version September 2010) and Behavioural Support meeting minutes for 2013/14.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dining Observation
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Training and Orientation

Findings of Non-Compliance were found during this inspection.

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. 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).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, Chapter 8, s. 6. (1) in that the licensee did not ensure that there was a written plan of care for each resident that

sets, (a) the planned care for the resident, (b) the goals the care is intended to achieve; and (c) clear direction to staff and others who provide direct care to the resident, as evidenced by Resident #1, Resident #2 and Resident #5.

Related to Resident #1
Resident #1's resides on the secured dementia unit. The resident's health care file indicates he/she is mentally challenged. He/she is independent with mobility, is resistive to care, refuses medications at times and has been physically and verbally aggressive towards co-residents.

During an interview on April 28, 2014 with the day RPN S#101, it was indicated to Inspector #549 that Resident #1 was being monitored for inappropriate sexual behaviours towards co-residents.

During an interview on April 29, 2014 with the Behavioural Support Outreach (BSO) PSW S#105, it was confirmed that Resident #1 does have inappropriate sexual behaviour towards a co-resident. S#105 indicated the behaviour was being managed through redirection interventions.

Resident #1 was seen by a psychiatrist from the Royal Ottawa Psychiatry Outreach in December 2013 and January 2014 to address inappropriate sexual behaviour towards a co-resident and agitation when re-directed. Recommendations from the psychiatrist concerning the sexual behaviour towards co-resident are for staff to provide boundaries to what is allowed as Resident #1 cognitively is unable to do this.

The electronic progress notes for Resident #1 documented there were five separate occasions where Resident #1 exhibited inappropriate sexual behaviour. A Critical Incident Report was completed for a specific date in April 2014. These incidents of inappropriate sexual behaviour have been directed towards the same co-resident.

The electronic progress notes indicate Resident #1 refused anti-anxiety medications on several dates.

Critical Incident Report for specific date in February 2014 indicates Resident #1 attempted to choke a co-resident. The Critical Incident states Resident #1 had refused morning medication.

Upon review of Resident #1's written Care Plan there is no planned care for the

inappropriate sexual behaviour towards a co-resident or refusal of medications, goals the care intended to achieve; and clear direction to staff and others who provide direct care to Resident #1.

Related to Resident #2
Resident #2 resides on the secured dementia unit. The resident's health care file indicates a diagnosis of unspecified dementia, congestive heart failure, ataxia and stoke,independent with mobility, is unable to express self verbally at times and wanders into other residents' rooms and will attempt to leave the unit; Resident #1 has been physically aggressive with Resident #2 on several occasions.

During an interview on April 28, 2014 with RPN S#101, it was indicated to Inspector #549 that when Resident #2 gets up in the morning, is to be given breakfast as soon as possible, to ensure Resident #2 eats then leaves the dining room to prevent any responsive behaviours due to loud noises in the dining room. RPN S#101 indicated that Resident #2 will become particularly agitated if a co-resident starts to yell near Resident #2.

During an interview on April 29, 2014 RN S#103 indicated to Inspector #549 that Resident #2 needs to be toileted as soon as possible as a delay will trigger a responsive behaviour. PSW S#102 who was assigned to Resident #2 at the time did not know this information when Inspector #549 inquired.

Documentation on the Critical Incident System Report submitted to the Ministry of Health and Long Term Care, on a specific date in February 2014 states Resident#1 sustained a bruise and a skin tear from Resident #2; Resident #2 has recently shown an increase in responsive behaviours such as pushing people aside and striking out.

Resident #2 was seen by a psychiatrist from the Royal Ottawa Geriatric Psychiatry Outreach on a specific date in April 2014. The psychiatrist indicated Resident #2 misinterprets situations and cannot figure out how to resolve them.

Upon review of Resident #2's written Care Plan there is no planned care for these responsive behaviours or how to manage the misinterpretation of situations, goals the care intended to achieve; and clear direction to staff and others who provide direct care to Resident #2.

Related to Resident #5

Resident #5 resides on the secured dementia unit. The resident has a psychiatric disorder with delusions and depression. Resident #5 tends to irritate co-residents from time to time asking the same questions over and over. The resident does not have a history of aggression. There is documentation stating Resident #5 will ask others for sex.

On April 29, 2014 during an interview with day RN S#103, it was indicated to Inspector #549 that Resident #5 needs to be monitored when sitting by the elevator on the unit as Resident #1 will sexually inappropriately touch Resident #5.

Upon Review of Resident #5's written care plan there is no planned care, goals the care intended to achieve; and clear direction to staff and others who provide direct care to the resident related to this behaviour.

Review of the home's Responsive Behaviour policy number 09-05-01 (current version: September 2010), in the Resident Care Manual bullet 8 states: The care plan is to contain information related to each behaviour observed and should include at a minimum: a) Triggers to behaviours, b) Ways to complete a task or ADL that minimize the likelihood of the behaviour appearing, c) What the behaviour actually is, d) Interventions to deal with the behaviour, e) What to do if the interventions are not effective and/or if the behaviour escalates, f) Fluctuations in the resident behaviour including times when the behaviour is more prevalent and time when the behaviour is non-existent.

The BSO PSW S#105 stated to Inspector #549 there is assistance for staff with managing behaviours, although there is no documentation of interventions as it is verbally communicated to the staff at the time of the assistance.

The Administrator, Director of Care, Assistant Director of Care, RN S#103 and RPN S#101 indicated to Inspector #549 the written Care Plan is the tool used by the home to provide clear directions to the front line staff to provide care to the residents. [s. 6. (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 comply with the LTCHA 2007, Chapter 8, s. 19(1) in that the licensee did not protect Resident #5 from abuse.

Resident #1 resides in the secured dementia unit. The resident has a diagnosis of being mentally challenged and can be verbally aggressive with staff.

The following is documented in Resident #1's health record:

On a specific date in March 2014, Resident #1 has been touching a co-resident inappropriately, as well as touching self with other hand.

On a specific date in March 2014, HCA reported to both RPNs that Resident #1 was fondling a co-resident at the dining table. Both were moved away from each other. Writer mentioned to ADOC that the resident's behaviour seems to be increasing.

On a specific date in April 2014, Resident #1 was found trying to touch a co-resident inappropriately; the co-resident was moved and Resident#1 was reminded of improper behaviour.

On a specific date in April 2014, HCA reported to seeing Resident #1 fondling a co-resident. Resident #1 was removed and told that the behaviour is unacceptable.

Resident #1 was seen on specific dates in December 2013 and January 2014 by the Royal Ottawa Psychiatry Outreach Program; the recommendations were to monitor Resident #1's inappropriate sexual behaviour and staff is to be vigilant when Resident #1 is near co-resident. The psychiatrist also reported that the home will have to provide boundaries to what is allowed as Resident #1 is cognitively unable to do so.

Resident #5 resides on the secured dementia unit. Resident #5 has a diagnosis of Chronic Schizophrenia with delusions and depression. Resident #5 does not have a

history of aggression with co-residents.

There is an Order that requires Resident #5 to be compliant with taking anti-psychotic medications. Resident #5 is seen every month by a psychiatrist, who ensures that the resident receives anti-psychotic medication to control Resident #5's sexual behaviour.

The following is documented in Resident #5's health record:

On a specific date in March 2014, two reddened areas were found on resident's lower abdominal quadrants this am. LLQ bruise measures 3.5 X 2.5 while RLQ bruise, which measures 3 X 1.5, is more diffuse and less intense.

On a specific date in April 2014, a co-resident touched resident #5 inappropriately. The co-resident was re-directed.

During an interview with Inspector #549, RPN #101 and RN #103 indicated that Resident #1 had not been inappropriately sexually touching any other residents on the secured dementia unit other than Resident #5.

On a specific day in May 2014, during an interview with RPN #111, it was indicated to Inspector #549 that the incidents between Resident #1 and Resident #5 met the definition of sexual abuse and should be reported as per the home's policy titled Resident Abuse By Persons Other Than Staff # OPER-02-02-04.

The Director of Care and the Assistant Director of Care stated to Inspector #549 during an interview on April 30, 2014, that neither Resident #1 nor Resident #5 is capable of consent and do not understand why staff did not report the incidents of inappropriate sexual touching that occurred between Resident #1 and Resident #5.

RPN #101 and RN #103 stated when Resident #1's inappropriate sexual behaviour towards Resident #5 is observed, staff will move Resident #1 from the area where Resident #5 is sitting.

The Director of Care and Assistant Director of Care indicated to Inspector #549 during an interview on May 1, 2014, that the intervention of moving Resident #1 away from Resident #5 was not effective in managing the inappropriate sexual behaviour as the inappropriate sexual behaviour was repeated.

There was no effective communication between staff, either verbally or through the plan of care as to how to manage Resident #1's inappropriate sexual behaviour.

Upon review of Resident #1 and Resident #5's written plan of care, there is no planned care, goals the care intended to achieve; and clear direction to staff and others who provide care to the resident related to these behaviours. (as identified in WN#1, CO#-001)

The Director was not immediately notified when there was an alleged, suspected or witnessed incident of abuse of Resident #5 that has occurred or may occur that resulted in harm or a risk of harm. (as identified in WN#3)

Resident #5's SDM was not immediately notified of the alleged, suspected or witnessed incidents of sexual abuse of the resident that has occurred or may occur that resulted in harm or a risk of harm. (as identified in WN# 5)

The appropriate police force was not immediately notified of any alleged, suspected or witnessed incidents of abuse or neglect or a resident. (as identified in WN# 6)

The Director of Care informed Inspector #549 on May 2, 2014, that extra staff was scheduled to provide on-going 1:1 monitoring of Resident #1. The Royal Ottawa Psychiatry Outreach Team was contacted on April 30, 2014 to assist staff with Resident #1's inappropriate sexual behaviour; arrangements are in process for the transfer of Resident #1 to a more suitable unit within the home. Registered staff has been assigned to update the written plan of care to include behaviour management. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, Chapter 8 s.24 (1) in that the licensee did not immediately report to the Director an incident of suspected sexual abuse of a resident that has occurred or may occur that resulted in harm or a risk of harm to a resident.

Review of Resident #1's progress notes indicated several incidents of suspected or actual sexual abuse by Resident #1 towards a co-resident between March and April 2014. When staff observed the inappropriate sexual behaviour, it was documented in Resident #1's and Resident #5's health care file.

The Director of Care confirmed to Inspector #549 that these incidents of suspected or actual sexual abuse were not reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident that the suspicion and the information upon which it is based it immediately reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, Chapter 8, S. 3. (1) 11. iv in that the licensee did not ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

The Behavioural Support Team Meeting minutes of June 2013 were posted on the Behaviour Support Bulletin Board which is located down a hallway that leads to the Chapel, Conference Room, Physiotherapy Room, several managers' offices and the staff lockers. This hallway is also accessible to the residents, staff and general public.

The Behavioural Support Team Meeting minutes contained resident names, diagnoses and treatment plans.

Inspector #549 observed several visitors, residents, staff and outside contract personnel use this particular hallway throughout the inspection. [s. 3. (1) 11. iv.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The Licensee has failed to comply with O. Reg. 79/10 s.97.(1) in that the licensee did not ensure that the resident's substitute decision-maker was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse that resulted in a physical injury or pain to the resident or caused distress to the resident that could potentially be determined to the resident's health or well being.

A review of Resident #1's progress notes indicated several incidents of suspected or actual sexual abuse by Resident #1 towards a co-resident between March and April 2014. When staff observed the inappropriate sexual behaviour, it was documented in Resident #1's and Resident #5's health care record.

In discussion with RN S#103 and RPN S#101, the incidents of sexual abuse with Resident #1 are targeted towards Resident #5. Both S#103 and S#101 stated all incidents with Resident #1 occurred with Resident #5.

The Director of Care confirmed to Inspector #549 that these incidents of suspected or actual sexual abuse were not reported to the Resident #5's substitute decision-maker. [s. 97. (1) (a)]

WN #6: 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 comply with the LTCHA 2007, Chapter 8, s. 98 in that the licensee did not ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect.

Resident #1's progress notes indicate that there were four separate incidents of suspected sexual abuse which occurred between March and April 2014.

On April 29, 2014 the Director of Care and the Assistant Director of Care stated that police were not notified of these incidents of alleged, suspected or witnessed incidents of abuse or neglect of a resident. [s. 98.]

Issued on this 23rd day of May, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Rena Bowen #549.

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RENA BOWEN (549)
Inspection No. / No de l'inspection :	2014_288549_0021
Log No. / Registre no:	O-000140,O-000297,O-000380-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 22, 2014
Licensee / Titulaire de permis :	NEW ORCHARD LODGE LIMITED 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE WEST END VILLA 2179 ELMIRA DRIVE, OTTAWA, ON, K2C-3S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KELLY CLOUTIER

To NEW ORCHARD LODGE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare,submit and implement a plan to ensure that the plan of care for every resident identified as demonstrating responsive behaviours of physical, verbal and/or sexual aggression and/or abuse is reviewed and revised to provide clear direction to staff.
The plan shall include a process to identify behavioural triggers, strategies and interventions on how to manage the responsive behaviours and the process to reassess the resident and revise the plan of care when interventions for the responsive behaviours are not effective.

The plan shall be submitted in writing by May 30,2014 to inspector Rena Bowen, Ministry of health and Long term care, by email to Rena.Bowen@ontario.ca

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, Chapter 8, s. 6. (1) in that the licensee did not ensure that there was a written plan of care for each resident that sets, (a) the planned care for the resident, (b) the goals the care is intended to achieve; and (c) clear direction to staff and others who provide direct care to the resident, as evidenced by Resident # 1, Resident #2 and Resident #5.

Related to Resident #1
Resident #1's resides on the secured dementia unit. The resident's health care file indicates he/she is mentally challenged. He/she is independent with mobility, is resistive to care, refuses medications at times and has been physically and

verbally aggressive towards co-residents.

During an interview on April 28, 2014 with the day RPN S#101, it was indicated to Inspector # 549 that Resident #1 was being monitored for inappropriate sexual behaviours towards co-residents.

During an interview on April 29, 2014 with the Behavioural Support Outreach (BSO) PSW S#105, it was confirmed that Resident #1 does have inappropriate sexual behaviour towards a co-resident. S#105 indicated the behaviour was being managed through redirection interventions.

Resident #1 was seen by a psychiatrist from the Royal Ottawa Psychiatry Outreach in December 2013 and January 2014 to address inappropriate sexual behaviour towards a co-resident and agitation when re-directed. Recommendations from the psychatrist concerning the sexual behaviour towards co-resident are for staff to provide boundaries to what is allowed as Resident #1 cognitively is unable to do this.

The electronic progress notes for Resident # 1 documented there were five separate occasions where Resident # 1 exhibited inappropriate sexual behaviour. A Critical Incident Report was completed for a specific date in April 2014. These incidents of inappropriate sexual behaviour have been directed towards the same co-resident.

The electronic progress notes indicate Resident #1 refused anti-anxiety medications on several dates.

Critical Incident Report for a specific date in February 2014 indicates Resident #1 attempted to choke a co-resident. The Critical Incident states Resident #1 had refused morning medication.

Upon review of Resident #1's written Care Plan, there is no planned care for the inappropriate sexual behaviour towards a co-resident or refusal of medications, goals the care intended to achieve; and clear direction to staff and others who provide direct care to Resident # 1.

Related to Resident #2
Resident #2 resides on the secured dementia unit. The resident's health care file indicates a diagnosis of unspecified dementia, congestive heart failure, ataxia

and stoke, independent with mobility, is unable to express self verbally at times and wanders into other residents' rooms and will attempt to leave the unit; Resident #1 has been physically aggressive with Resident #2 on several occasions.

During an interview on April 28, 2014 with RPN S#101, it was indicated to Inspector #549 that when Resident #2 gets up in the morning, is to be given breakfast as soon as possible, to ensure Resident #2 eats then leaves the dining room to prevent any responsive behaviours due to loud noises in the dining room. RPN S#101 indicated that Resident #2 will become particularly agitated if a co-resident starts to yell near Resident #2.

During an interview on April 29, 2014 RN S# 103 indicated to Inspector #549 that Resident #2 needs to be toileted as soon as possible as a delay will trigger a responsive behaviour. PSW S#102 who was assigned to Resident #2 at the time did not know this information when Inspector #549 inquired.

Documentation on the Critical Incident System Report submitted to the Ministry of Health and Long Term Care, on a specific date in February 2014 states Resident #1 sustained a bruise and a skin tear from Resident #2; Resident #2 has recently shown an increase in responsive behaviours such as pushing people aside and striking out.

Resident # 2 was seen by a psychiatrist from the Royal Ottawa Geriatric Psychiatry Outreach on a specific date in April 2014. The psychiatrist indicated Resident #2 misinterprets situations and cannot figure out how to resolve them.

Upon review of Resident # 2's written Care Plan, there is no planned care for these responsive behaviours or how to manage the misinterpretation of situations, goals the care intended to achieve; and clear direction to staff and others who provide direct care to Resident # 2.

Related to Resident #5
Resident #5 resides on the secured dementia unit. The resident has a psychiatric disorder with delusions and depression. Resident #5 tends to irritate co-residents from time to time asking the same questions over and over. The resident does not have a history of aggression. There is documentation stating Resident #5 will ask others for sex.

On April 29, 2014 during an interview with day RN S#103, it was indicated to Inspector #549 that Resident #5 needs to be monitored when sitting by the elevator on the unit as Resident #1 will sexually inappropriately touch Resident #5.

Upon Review of Resident #5's written care plan, there is no planned care, goals the care intended to achieve; and clear direction to staff and others who provide direct care to the resident related to this behaviour.

Review of the home's Responsive Behaviour policy number 09-05-01(current version: September 2010), in the Resident Care Manual bullet 8 states: The care plan is to contain information related to each behaviour observed and should include at a minimum: a) Triggers to behaviours, b) Ways to complete a task or ADL that minimize the likelihood of the behaviour appearing, c) What the behaviour actually is, d) Interventions to deal with the behaviour, e) What to do if the interventions are not effective and/or if the behaviour escalates, f) Fluctuations in the resident behaviour including times when the behaviour is more prevalent and time when the behaviour is non-existent.

The BSO PSW S#105 stated to Inspector #549 there is assistance for staff with managing behaviours, although there is no documentation of interventions as it is verbally communicated to the staff at the time of the assistance.

The Administrator, Director of Care, Assistant Director of Care, RN S#103 and RPN S#101 indicated to Inspector #549 the written Care Plan is the tool used by the home to provide clear directions to the front line staff to provide care to the residents.

(549)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 22nd day of May, 2014

Signature of Inspector / Signature de l'inspecteur : Rena Bowen #549

Name of Inspector / Nom de l'inspecteur : Rena Bowen

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