Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 11, 2015	2015_168202_0016	T-2910-15	Critical Incident System

Licensee/Titulaire de permis

ORILLIA LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

LEACOCK CARE CENTRE
25 MUSEUM DRIVE ORILLIA ON L3V 7T9

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

VALERIE JOHNSTON (202), MONICA NOURI (193)

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): July 28, 29, 30, 31, August 04, and September 18, 21, 22, 23, 2015.

During the course of this inspection the inspector: reviewed clinical records, observed resident to resident and staff to resident interactions, reviewed the one to one staffing schedule, the home's internal investigation, staff training records and pertinent policies and procedures.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), staff education coordinator (SEC), responsive behaviour program lead, restorative care coordinator (RCC), registered nursing staff, personal support workers, and family members.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

The licensee has failed to ensure that 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 that minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #002 had been identified with responsive behaviours that pose a risk toward an identified resident and other residents residing on a identified home area. Resident #002's responsive behaviours are unpredictable and as a result residents and staff have been at risk of harm and harmed since resident #002's admission.

Interviews with RN #101, RPN #120, and PSW's #103, #104, #105, #118, #119 and #100 indicated that any resident that passes or walks by resident #002 have been subject to resident #002's identified responsive behaviours. Staff indicated that it has been difficult to manage resident #002's identified behaviours and are frustrated with the lack of developed strategies and interventions that would assist in minimizing potential altercations that have the ability to harm residents, staff and most notable an identified resident that has been targeted.

A review of resident #002's clinical records indicated that the resident had been assessed by a behavioural assessment team/ Mobile Support Team (MST) for an identified period of time. From the time of discharge from the MST program and for the following six months, resident #002 had multiple accounts documented of identified behaviours toward an identified resident and co residents.

An interview with the SEC revealed that it was not until after receiving notification from the coroner on an identified date, informing the home that the police would be investigating an incident that occurred between resident #001 and #002, that the home sought support from the Behavioural Interventions and Response Team (BIRT) as directed by corporate office.

An interview with the responsive behaviour lead indicated that a Dementia Observation System (DOS) tracking tool had not been initiated by registered staff for the six months post discharge from the MST program, which may have prompted an earlier referral to community behavioural resources. The lead expressed an unawareness of the ongoing

altercations and potentially harmful interactions between resident #002 and other residents on the identified home area.

The Behavioural Response Team (BIRT) notes for three identified dates within a one month period of time, revealed an assessment and confirmation that the home had requested BIRT's assistance in the development of interventions in relation to the escalation of the identified responsive behaviours directed at co-residents by resident #002.

Proceeding the assessments, the BIRT team provided the home with a care conference and twelve written recommendations that would assist staff in responding to resident #002’s identified responsive behaviours and the targeting of an identified resident.

A comparison review of resident #002’s Kardex between the time of the BIRT assessment and for the preceding two months, revealed only one additional change which directed staff to re-direct the resident #002 to a quiet area when co-residents become agitated or loud. Interviews with PSW’s #118, #119 and #100 revealed no awareness that resident #002 had even been assessed by BIRT and the subsequent recommendations provided to the home.

The licensee failed to ensure that the plan of care for #002 contained any of the BIRT recommendations that would have assisted in the development of procedures and interventions to respond to resident #002's identified responsive behaviours.

The DOC revealed that the home and staff are aware of resident #002’s responsive behavior triggers that have posed a risk to both residents and staff, and most notably to an identified resident that had been targeted. The DOC further stated that the BIRT recommendations had only been discussed at management meetings and had not been assessed for the effectiveness as well as they could have been. As a result, the DOC indicated and confirmed that procedures and interventions had not been developed and implemented to assist residents and staff who are at risk of harm in response to resident #002’s identified unpredictable behaviours.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
Resident #002 identified with responsive behaviours that have been unpredictable and as a result residents and staff are at risk of harm and have been harmed as a result of resident #002's behaviours, from the time of the resident's admission. For an identified

six month period of time, resident #002's identified responsive behaviours had escalated, with documented accounts of responsive behaviours, specifically toward an identified resident. The home did not seek support from the Behavioural Interventions and Response Team (BIRT), until after a notification by the coroner had been received, indicating that the police would be investigating an incident that occurred between resident #002 and #001. BIRT provided the home with twelve recommendations proceeding three days of assessments, that included interventions that would assist residents and staff from being harmed as a result of resident #002's behaviour, including the identification that the targeted resident was a trigger for the identified responsive behaviours. The home implemented enhanced monitoring for resident #002 that was not provided consistently and with no interventions in place to assist staff when monitoring resident #002 when the enhanced monitoring was not available. Following the BIRT recommendations, the home had not assessed the BIRT recommendations or the effectiveness for use in resident #002 or the targeted resident's plan of care.
The scope of the non-compliance is isolated to an identified home area.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, O.Reg. 79/10., s. 55.: A voluntary plan of correction (VPC) was previously issued for O.Reg. 79/10.,s.55 (b) during a Resident Quality Inspection on November 28, 2014, under Inspection #2014_298557_0023.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

s. 6. (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 :

The licensee has failed to 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 the care set out in the plan has not been effective.

Resident #002 was admitted to the home on an identified date. Approximately four months after the resident's admission resident #002 was assessed by the Mobile Support Team (MST) of the North Simcoe Muskoka Behavioural Support System due to the resident's identified responsive behaviours. Proceeding the MST assessments, the resident was discharged from the MST program and a behavioural care plan was provided to the home.

As of the identified time of discharge and receipt of the MST care plan, resident #002's Kardex failed to include resident #002's identified behaviours, identified triggers, written strategies to respond to resident #002's responsive behaviours, or any other interventions or recommendations suggested by MST.

The initial month, following the MST suggestions, resident #002 continued to respond to

his/her surroundings with identified behaviours that had been documented, including the targeting of an identified resident. During this month, the resident had been assessed by the physician several times. The physician assessment notes indicated that the resident continues to be followed by MST and that staff were to continue with the current plan of care, despite the resident's discharge from the MST program a month prior.

For the following six months, resident #002 had multiple documented incidents of responsive behaviours and continued to target an identified resident. During this period of time, resident #002 had ten documented physician assessments, including a multidisciplinary care conference, held at the six month time period, indicating that there are no concerns and that staff are to continue with the current plan of care.

It was not until the home received a phone call from the coroner on an identified date during the seventh month that triggered a review of resident #002's plan of care. The SEC indicated in an interview that in light of the police and coroner investigation, he/she received direction from corporate office to send a referral to the Behavioural Intervention Response Team (BIRT) and initiated enhanced monitoring for resident #002. An interview with the lead of the behavioural program indicated that he/she had been unaware of resident #002's ongoing identified behaviours toward residents on the identified home area for an identified seven month period of time.

Resident #002 had been assessed by BIRT for three identified days during a one month time period and following the assessments, the BIRT team provided the home with identified triggers and twelve recommendations that would assist staff in responding to resident #002's responsive behaviours.

An interview with RN #101, indicated that he/she was aware that resident #002 had been assessed by the BIRT team and had recalled seeing the notes on the nursing station desk. The RN further revealed that any BIRT assessment notes are left on the nursing station desk for about a week so that staff may read them and then the notes are filed the resident's chart by the night shift.

Interviews with PSW's #100 and #119, revealed that they were not aware that resident #002 had been assessed by BIRT, had no knowledge of BIRT's recommendations and that they were only aware that resident #002 was having enhanced monitoring as a result of the "incident". RN #101, PSW's #100 and #119, further indicated in interviews that there had been no collaboration in the development of resident #002's plan of care and were not sure of what interventions the home had chosen to implement if any.

A review of the KARDEX with PSW #119 and RN #101, both confirmed that resident #002's was generic and did not include the resident's identified responsive behaviours, triggers for the resident's responsive behaviours, or specific interventions in responding to resident #02's responsive behaviours. A comparison review of resident #002's written plan of care and Kardex following the BIRT assessment and recommendations, revealed only one additional change directing staff to re-direct the resident when co-residents become agitated or loud with no evidence of collaborative intervention.

The DOC confirmed receipt of the BIRT recommendations, and indicated that all BIRT assessment notes had been discussed at management meetings. The DOC indicated that after the management meetings the BIRT assessments and recommendation notes had been placed at the nursing station for staff to review and that night shift staff are to file the notes in the resident's chart.

The DOC indicated that the home and staff are aware of resident #002's responsive behaviors and the identified triggers that had posed a risk to other residents, especially the identified resident that had been targeted. The DOC confirmed that resident #002's plan of care did not include any of the BIRT assessments or recommendations and that the plan of care only provided generic directions to staff and that the plan of care had been in effect since the resident's admission.

The DOC further indicated that although the BIRT assessment notes and recommendations had been reviewed by the management team, resident #002's plan of care had not been reviewed or revised to reflect any of the assessments or recommendations provided by BIRT.

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 ensure that staff and others involved in the different aspects of care collaborate with each other 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 and that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #009 must be based, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. Safety risks.

Resident #009 resides on an identified home area with resident #002. Record review and interviews with RN #101, PSW's #100, #106, revealed that resident #002 has identified responsive behaviours, has targeted resident #009 and resident #009 has been a recipient to resident #002's behaviours.

The progress notes for resident #009 revealed that the family of resident #009 had concerns for his/her mother/father's safety when residing near and on the same home area as resident #002.

A review of the BIRT care conference notes, indicated that the current accommodations for resident #009 was not in the best interest of resident #002 or resident #009 as responsive behaviours have been triggered by resident #009.

The DOC confirmed receipt of the BIRT recommendations and indicated that the home had discussed applying for high intensity needs funding for more appropriate accommodations for resident #002, but confirmed that this recommendation had only been discussed among the management team and no decision had been made.

The DOC confirmed that home had not assessed the safety risks for resident #009 and that resident's #009's plan of care did not include an assessment of risk associated with resident #009's accommodation and trigger for resident #002's behaviours.

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 of care be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. safety risks, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that strategies are developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Resident #002 had been identified with responsive behaviours that had posed a risk toward an identified resident and other residents residing on an identified home area.

Interviews with RN #101, RPN #120, and PSW's #103, #104, #105, #118, #119 and #100 indicated that resident #002 has identified responsive behaviours and has targeted an identified resident.

The above mentioned staff indicated that it has been difficult to manage resident #002's identified behaviours and are frustrated with the lack of developed strategies and interventions that would assist in minimizing potential altercations that have the ability to harm residents, staff and most notable an identified resident for which resident #002 has targeted.

A review of the Behavioural Response Team (BIRT) notes for three identified dates, revealed an assessment and confirmation that the home had requested BIRT's assistance in the development of interventions with relation to escalation of resident #002's identified responsive behaviours.

Proceeding the assessments, the BIRT team had provided the home with a care conference and twelve written recommendations that would assist staff in responding to resident #002's identified responsive behaviours.

The BIRT care conference notes identified that an identified resident was a trigger for resident #002's identified behaviours and provided the home with a recommendation.

The licensee failed to ensure that the plan of care for #002 failed to contain any of the BIRT recommendations that would have assisted in the development of procedures and interventions to respond to resident #002's identified responsive behaviours.

The DOC revealed that the home and staff are aware of resident #002's responsive behavior triggers that have posed a risk to both residents and staff, especially an identified resident residing on the same identified home area. The DOC further stated that the BIRT recommendations had only been discussed at management meetings and had not been assessed for the effectiveness as well as they could have been. As a result, the DOC indicated and confirmed that procedures and interventions had not been developed and implemented to assist residents and staff who are at risk of harm in response to resident #002's identified behaviours.

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 strategies are developed and implemented to respond to the resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Resident #002 had been identified with responsive behaviours that had posed a risk toward an identified resident and other residents residing on an identified home area.

Record review and interviews with RN #101, PSW's #100, #106 indicated that it has been difficult to manage resident #002's identified behaviours and are frustrated with the lack of developed strategies and interventions that would assist in minimizing potential altercations that have the ability to harm residents, staff and most notable an identified resident.

A review of resident #002's clinical records revealed that on an identified date, the BIRT team had provided the home with a care conference and twelve written recommendations that would assist staff in responding to resident #002's identified responsive behaviours.

The BIRT care conference notes, indicated that an identified resident was a trigger for resident #002's identified behaviours and provided the home with a written recommendation.

RN #101, RPN #120, and PSW's #118, #119, #100, indicated in interviews that the

enhanced monitoring for resident #002, that had been initiated on an identified date, had been a positive action in responding to resident #002's identified responsive behaviours. The above mentioned staff further indicated that although resident #002 had assigned enhanced monitoring, the plan of care for resident #002, did not include any strategies or interventions that would minimize the risk of altercations and potentially harmful interactions between residents, including the identified resident that had been targeted. Staff indicated also that there were no steps taken to minimize the risk of altercations when the enhanced monitoring had not been available.

The DOC revealed that the home and staff were aware of resident #002's identified responsive behavior triggers that potentiate a risk to both residents and staff. The DOC further stated that the BIRT recommendations had only been discussed at management meetings and had not been assessed for the effectiveness as well as they could have been.

RN #101 and RPN #120 indicated in interviews, that although the licensee initiated one to one staffing for resident #002, the licensee failed to ensure that interventions had been developed and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

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 steps taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually in areas mentioned in subsection (2) as provided for in the regulations.

Review of staff training records and interview with the Education Coordinator confirmed that not all staff had been retrained in 2014 in the following areas:
- 20% of staff had not received training, in the Resident Bill of Rights,
- 16% of staff had not received training on the home's zero tolerance of abuse and neglect of residents policy,
-14% of staff had not received training on the duty under section 24 to make mandatory reports, and
-16% of staff had not received training in the protections afforded by section 26 of the Act. [s. 76. (4)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf.

A review of the written plan of care for residents #002, #011, #012, and #013, revealed that all four residents had been assessed as a high risk for falls and required an identified item to be worn daily to prevent injury from falls.

A review of the home's Falls Prevention and Management Program policy, revised 2015-03-18, directs staff to ensure that the falls prevention equipment, supplies, devices and positioning aides are readily available in the home as required to reduce the incidence of falls and the risk of injury.

An interview with the RCC revealed that the identified items are part of the home's falls prevention program because the identified item prevents injury should a fall occur. The RCC further indicated that although the identified items are part of the home's falls prevention program, the home does not pay for or supply the identified item to residents that require them. The RCC further revealed that upon family approval to purchase the identified item, the home will order the required identified items from Shoppers Home Health Care and that the family is responsible for payment.

During an interview, a family member of resident #002 indicated that the family was asked by the home to purchase the identified item for resident #002 after an identified fall. The family member indicated that he/she agreed and purchased two identified items, $60 each, and brought them to the home.

Interview with the RCC and the administrator confirmed that the family of resident #002 had been asked to purchase an identified item and provided the family member's financial statement.

The RCC further revealed that the families of residents #011, #012, and #013 had also been asked to purchase identified items and confirmed that all of the above mentioned families had purchased the identified items and included in each resident's plan of care. [s. 91. (4)]

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

Issued on this 24th day of December, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202), MONICA NOURI (193)
Inspection No. / No de l'inspection :	2015_168202_0016
Log No. / Registre no:	T-2910-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 11, 2015
Licensee / Titulaire de permis :	ORILLIA LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	LEACOCK CARE CENTRE 25 MUSEUM DRIVE, ORILLIA, ON, L3V-7T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carrie Acton

To ORILLIA LONG TERM CARE CENTRE 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 :

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 :

Upon receipt of this order the licensee shall:

1. Within one week of receipt of this order, conduct a meeting between management and direct care staff from home area 4.

2. The meeting shall allow direct care staff opportunities to review resident #002's plan of care and the recommendations provided by BIRT. The meeting shall be collaborative and allow for the development and implementation of procedures and interventions to assist staff in responding to resident #002's responsive behaviours. The procedures and interventions must include strategies to minimize the risk of altercation or injury to the identified targeted resident.

3. The meeting shall ensure that the review, implementation and evaluation of all assessments and recommendations provided by the Behavioural Intervention Response Team (BIRT), received for resident #002 occur.

Minutes and attendance to be documented and forwarded to valerie.johnston@ontario.ca upon completion.

4. The licensee shall develop, implement and submit a plan, that includes the procedures and interventions developed to assist residents and staff who are at risk of harm as a result of a resident behaviours. The plan should also include, but not be limited to resident #002.

5. The plan is to include the required tasks, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to valerie.johnston@ontario.ca by January 15, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that 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 that minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #002 had been identified with responsive behaviours that pose a risk toward an identified resident and other residents residing on a identified home area. Resident #002's responsive behaviours are unpredictable and as a result

residents and staff have been at risk of harm and harmed since resident #002's admission.

Interviews with RN #101, RPN #120, and PSW's #103, #104, #105, #118, #119 and #100 indicated that any resident that passes or walks by resident #002 have been subject to resident #002's identified responsive behaviours. Staff indicated that it has been difficult to manage resident #002's identified behaviours and are frustrated with the lack of developed strategies and interventions that would assist in minimizing potential altercations that have the ability to harm residents, staff and most notable an identified resident that has been targeted.

A review of resident #002's clinical records indicated that the resident had been assessed by a behavioural assessment team/ Mobile Support Team (MST) for an identified period of time. From the time of discharge from the MST program and for the following six months, resident #002 had multiple accounts documented of identified behaviours toward an identified resident and co residents.

An interview with the SEC revealed that it was not until after receiving notification from the coroner on an identified date, informing the home that the police would be investigating an incident that occurred between resident #001 and #002, that the home sought support from the Behavioural Interventions and Response Team (BIRT) as directed by corporate office.

An interview with the responsive behaviour lead indicated that a Dementia Observation System (DOS) tracking tool had not been initiated by registered staff for the six months post discharge from the MST program, which may have prompted an earlier referral to community behavioural resources. The lead expressed an unawareness of the ongoing altercations and potentially harmful interactions between resident #002 and other residents on the identified home area.

The Behavioural Response Team (BIRT) notes for three identified dates within a one month period of time, revealed an assessment and confirmation that the home had requested BIRT's assistance in the development of interventions in relation to the escalation of the identified responsive behaviours directed at co-residents by resident #002.

Proceeding the assessments, the BIRT team provided the home with a care

conference and twelve written recommendations that would assist staff in responding to resident #002's identified responsive behaviours and the targeting of an identified resident.

A comparison review of resident #002's Kardex between the time of the BIRT assessment and for the preceding two months, revealed only one additional change which directed staff to re-direct the resident #002 to a quiet area when co-residents become agitated or loud. Interviews with PSW's #118, #119 and #100 revealed no awareness that resident #002 had even been assessed by BIRT and the subsequent recommendations provided to the home.

The licensee failed to ensure that the plan of care for #002 contained any of the BIRT recommendations that would have assisted in the development of procedures and interventions to respond to resident #002's identified responsive behaviours.

The DOC revealed that the home and staff are aware of resident #002's responsive behavior triggers that have posed a risk to both residents and staff, and most notably to an identified resident that had been targeted. The DOC further stated that the BIRT recommendations had only been discussed at management meetings and had not been assessed for the effectiveness as well as they could have been. As a result, the DOC indicated and confirmed that procedures and interventions had not been developed and implemented to assist residents and staff who are at risk of harm in response to resident #002's identified unpredictable behaviours.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
Resident #002 identified with responsive behaviours that have been unpredictable and as a result residents and staff are at risk of harm and have been harmed as a result of resident #002's behaviours, from the time of the resident's admission. For an identified six month period of time, resident #002's identified responsive behaviours had escalated, with documented accounts of responsive behaviours, specifically toward an identified resident. The home did not seek support from the Behavioural Interventions and Response Team (BIRT), until after a notification by the coroner had been received, indicating that the police would be investigating an incident that occurred between resident #002 and #001. BIRT provided the home with twelve recommendations proceeding three days of assessments, that included interventions that would

assist residents and staff from being harmed as a result of resident #002's behaviour, including the identification that the targeted resident was a trigger for the identified responsive behaviours. The home implemented enhanced monitoring for resident #002 that was not provided consistently and with no interventions in place to assist staff when monitoring resident #002 when the enhanced monitoring was not available. Following the BIRT recommendations, the home had not assessed the BIRT recommendations or the effectiveness for use in resident #002 or the targeted resident's plan of care.
The scope of the non-compliance is isolated to an identified home area.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, O.Reg. 79/10., s. 55.: A voluntary plan of correction (VPC) was previously issued for O.Reg. 79/10.,s.55 (b) during a Resident Quality Inspection on November 28, 2014, under Inspection #2014_298557_0023. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 29, 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
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 11th day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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