Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY-JEAN SCHIENBEIN (158)
Inspection No. / No de l'inspection :	2012_140158_0002
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jan 30, Feb 2, 3, 4, 6, 22, 23, 24, 27, 2012
Licensee / Titulaire de permis :	THE CITY OF GREATER SUDBURY 200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3
LTC Home / Foyer de SLD :	PIONEER MANOR 960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TONY PARMAR

To THE CITY OF GREATER SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the substitute decision-makers for residents of the home, are given an opportunity to participate fully in the development and implementation of the resident's plan of care.
This same issue was previously identified in inspection # 2011_099188_0019 and CO# 003

Grounds / Motifs :

1. The licensee did not ensure that the resident's Power Of Attorney/ Substitute Decision-Maker(POA/SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care. A resident's progress notes identified staff's concern related to the resident's toileting assistance and transfers onto the toilet with the hygienic sling. A referral was sent to the physiotherapist (PT) to assess the resident's upper trunk control. The resident's progress notes identified that the (PT) was in to assess the resident's sitting and balance ability and changed the resident's plan of care to reflect the resident's newly assessed needs. It is identified 10 days later in the resident's progress notes that the resident's SDM was upset that the resident's plan of care was changed without the SDM's involvement. The resident's SDM was not given the opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S.O.2007, c.8, s. 6(5)] (158)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 23, 2012

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

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 ensure that there is a written plan of care for all residents who display responsive behaviours that sets out clear directions to staff and others who provide direct care to the residents.

Grounds / Motifs :

1. The licensee did not ensure that a resident's plan of care set out clear directions to staff and others who provide direct care to a resident. A resident who is dependent on staff for mobility and unable to communicate consent was inappropriately touched sexually by another resident. The progress notes of the resident who inappropriately touched other residents sexually were reviewed on February 2/11 and the following was documented:
- nine months prior to the above incident, the resident who inappropriately sexually touches other residents was found in the room of the resident involved in the above incident attempting to assist the resident out of bed and also kiss the resident x 3.
- seven and eight months prior to the incident, this resident was observed by staff to inappropriately sexually touch two other residents.
- eighteen days post incident, this resident was observed to attempt to inappropriately touch another resident sexually.
Although, the "Dementia Observation System Records(DOS) documentation were completed by the PSWs, an analysis of the resident who inappropriately touches other residents sexually was not completed and subsequently a plan of care was not developed until after the incident involving the resident who was dependent on staff for mobility and unable to communicate consent, even though the sexual touching/inappropriateness was first identified nine months prior. An intervention " protect other residents if unable to protect themselves" was identified in the plan of care of the resident who displayed inappropriately sexual touching, however, clear direction to staff and others is not provided. The inspector identified the above unclear direction to a RPN on February 2/12, who in turn brought this to the attention of the Program Coordinator. An updated plan of care which included clear direction to manage the sexual inappropriateness was then provided to the inspector on February 3/12. The resident's written plan of care did not set out clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c. 8, s. 6.(1)(c)] (158)
2. There were three episodes of a resident exit seeking in the resident's progress notes. In one of these episodes, the resident was found outside. The resident's plan of care did not include the exit seeking behaviour nor provide direction to staff and others who provide direct care to the resident. Other behaviours, such as wandering, agitation, refusing baths and verbal aggression were also found documented in the resident's progress notes, however, the plan of care contained no reference to these behaviours and therefore, did not set out clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O.2007, c.8, s. 6 (1)(c)] (158)
3. The licensee did not ensure that that there is a written plan of care that sets out clear directions to staff and others who provide direct care to the resident. A resident's progress notes were reviewed on February 3/12 and identified that the resident had several episodes of agitated behaviour in a period of a month. The resident's plan of care reviewed by the inspector on February 3/12 did not include agitated behaviours or set out clear direction to manage the resident's agitation. Specific interventions identified in the resident's progress notes post incident were not included in the resident's plan of care and therefore clear direction was not provided.
[LTCHA 2007, S.O.2007, c.8, s. 6(1)(c)] (158)
4. A resident became angry and was physically aggressive with a staff member when the staff member informed the resident that the narcotic previously taken was discontinued. The resident's health care record identified a past history of substance abuse. Discussion with the doctor on February 2/12 identified that substance abuse continues to be one of the resident's problems which the home is attempting to manage. It was also identified, by the doctor, that the resident's physical and verbal aggressive behaviour had escalated. The resident's progress notes identified that the resident expressed lack of pain control even though they were still taking the narcotic. There was further documentation noted in the resident's progress notes identifying the desire to die related to lack of pain control. The resident's plan of care does identify verbal aggression, however, physical aggression is not included. Interventions and triggers related to the physical aggression were also not included in the plan of care. The resident's plan of care does not include interventions to manage the resident's suicidal verbalization. The plan of care does not set out clear direction to staff and others who provide direct care to the resident.
[LTCHA 2007, S.O. 2007, c. 8, s. 6.(1)(c)] (158)
5. A resident reported to a RPN that a PSW treated them roughly when sitting in the lounge area. A different PSW identified to the inspector on February 3/12 that the resident requires 1 person assistance to stand when

transferring but will often self transfer or forget that assistance is needed and become resistive to care. These behaviours also escalate when the resident has a UTI. The resident's progress notes identified several episodes of resisting assistance with personal care. The DOS charting which was completed by the PSWs identified several episodes of the resident self transferring. A RPN identified that the resident has a current infection. The resident's plan of care was reviewed on February 3/12. Behaviours, such as self transferring, resisting care and interventions for infection were not included. The resident's plan of care does not set out clear direction to staff and others who provide direct care. [LTCHA 2007, S.O. 2007, c. 8, s. 6.(1)(c)] (158)
6. A resident who was asleep in bed was punched unexpectedly by another resident. A family member of the resident who was punched identified to the inspector on February 3/12 that the resident continues to be frightened by loud and aggressive residents. The resident's plan of care was reviewed on February 3/12 and fear and anxiety related to other resident's loud and aggressive behaviour was not included. The PSW assigned to the resident on February 3/12 was not aware of the resident's anxious behaviour. The resident's plan of care did not provide clear direction to staff and others who provide care. [LTCHA 2007, S.O. 2007, c. 8, s. 6.(1)(c)] (158)
7. A resident unexpectedly physically aggressive to another resident who was in bed. The physically aggressive resident's progress notes identified many entries that the resident was verbally and physically aggressive with staff and other residents prior to above incident. The Program Coordinator confirmed on February 2/12 that the resident had hit other residents before but did not cause them injury. The physically aggressive resident's plan of care was reviewed on Feb 3/12. Different approaches the staff could take related to the physical aggression towards them was identified, however, interventions to manage the resident's aggression towards other residents were not included. The resident's plan of care did not set out clear direction to staff and others who provide direct care. [LTCHA 2007, S.O. 2007, c. 8, s. 6.(1)(c)] (158)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 23, 2012

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

Order / Ordre :

The licensee shall ensure that, for any resident demonstrating responsive behaviours that strategies are developed and implemented to respond to these behaviours.

Grounds / Motifs :

1. A resident became angry and was physically aggressive with a Registered staff member when the staff member informed the resident that the narcotic the resident had been receiving was discontinued. The resident's physical and verbal aggressive behaviour had escalated with the home's attempts to manage the resident's pain. As well. the resident's progress notes identified that the resident had voiced suicidal thoughts. The resident's plan of care does identify interventions to manage verbal aggression, however, the resident's physical aggression is not included. Strategies have not been developed or implemented to respond to the resident's physical aggression. [O. Reg. 79/10, s. 53 (4)(b)] (158)
2. The licensee did not ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours. A resident's progress notes were reviewed on February 3/12 and identified that the resident had several episodes of agitated behaviour in the a period of a month. The resident's plan of care reviewed by the inspector on February 3/12 did not include agitated behaviours or provide strategies to manage the resident's agitation. Strategies were not developed or implemented to respond when the resident demonstrated responsive behaviours. [O. Reg. 79/10, s. 53 (4)(b)] (158)
3. The licensee did not ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours. A resident's health care record was reviewed on February 2/12 and identified behaviours such as, refusing care, verbal aggression, exit seeking, wandering and inappropriate sexual behaviour which occurred between May/11 and January/12. The resident's printed plan of care dated December/11 was reviewed on February 2/12. Inappropriate sexual behaviour was identified on the plan of care, however, strategies to manage the resident's wandering, exit seeking and refusal of care behaviours were not developed. The home's policies, " Behaviour Assessment and Interventions and Responsive Behaviours-Management " were reviewed on February 3/12. According to the home's "Behavioural Management Decision – Tree", an observational assessment of the resident's behaviour is done , followed by an analysis of triggers or factors related to the behaviour and resulting in interventions to manage the behaviour. Although, the "Dementia Observation System Records (DOS)" were documented by the PSWs, an analysis by the nursing staff of the resident's behaviour was not completed and subsequently written strategies and interventions were not developed or implemented. [O. Reg. 79/10, s. 53 (4)(b)] (158)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 23, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

Issued on this 27th day of February, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KELLY-JEAN SCHIENBEIN

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 30, Feb 2, 3, 4, 6, 22, 23, 24, 27, 2012	2012_140158_0002	Critical Incident

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Program Coordinators (PC), the physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the scheduling clerk, the administrative assistant, residents and families.

During the course of the inspection, the inspector(s) reviewed the following home's policies, Abuse: Resident Abuse/Mistreatment, Pain and Symptom Management, Program Policy and Behaviour Assessment and Interventions and Responsive Behaviours-Management of, the Ministry of Health and Long-Term Care (MOHLTC) critical incidents, and reviewed residents' health care records.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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).

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

s. 6. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. A resident who was asleep in bed was punched unexpectedly by another resident.
A family member of the resident who was punched identified to the inspector on February 3/12 that the resident continues to be frightened by loud and aggressive residents. The resident's plan of care was reviewed on February 3/12 and fear and anxiety related to other resident's loud and aggressive behaviour was not included. The PSW assigned to the resident on February 3/12 was not aware of the resident's anxious behaviour.
The resident's plan of care did not provide clear direction to staff and others who provide care. [LTCHA 2007, S.O. 2007, c. 8, s. 6.(1)(c)]
2. A resident unexpectedly physically aggressive to another resident who was in bed.
The physically aggressive resident's progress notes identified many entries that the resident was verbally and physically aggressive with staff and other residents prior to above incident. The Program Coordinator confirmed on February 2/12 that the resident had hit other residents before but did not cause them injury. The physically aggressive resident's plan of care was reviewed on Feb 3/12. Different approaches the staff could take related to the physical aggression towards them was identified, however, interventions to manage the resident's aggression towards other residents were not included.
The resident's plan of care did not set out clear direction to staff and others who provide direct care. [LTCHA 2007, S.O. 2007, c. 8, s. 6.(1)(c)]
3. A resident reported to a RPN that a PSW treated them roughly when sitting in the lounge area. A different PSW identified to the inspector on February 3/12 that the resident requires 1 person assistance to stand when transferring but will often self transfer or forget that assistance is needed and become resistive to care. These behaviours also escalate when the resident has a UTI.
The resident's progress notes identified several episodes of resisting assistance with personal care. The DOS charting which was completed by the PSWs identified several episodes of the resident self transferring.
A RPN identified that the resident has a current infection.
The resident's plan of care was reviewed on February 3/12. Behaviours, such as self transferring, resisting care and interventions for infection were not included.
The resident's plan of care does not set out clear direction to staff and others who provide direct care.
[LTCHA 2007, S.O. 2007, c. 8, s. 6.(1)(c)]
4. The home's Pain and Symptom Management Program Policy was reviewed on February 2/12 and identified that pain assessments are to be "completed on admission, quarterly and PRN".
A resident's quarterly pain assessment identified that they had moderate pain daily for which a narcotic is administered for pain control.
The resident's progress notes identified that they expressed lack of pain control even though the resident was still taking the narcotic.
The resident became angry and was physically aggressive with a staff member when the staff member informed the resident that the narcotic previously taken was discontinued.
A subsequent pain assessment was not completed.
The resident was not reassessed nor was the plan of care reviewed and revised when the resident's care needs related to pain had changed.
[LTCHA 2007, S.O. 2007, c. 8, s. 6.(10)(b)]
5. A resident became angry and was physically aggressive with a staff member when the staff member informed the resident that the narcotic previously taken was discontinued.
The resident's health care record identified a past history of substance abuse.
Discussion with the doctor on February 2/12 identified that substance abuse continues to be one of the resident's problems which the home is attempting to manage. It was also identified, by the doctor, that the resident's physical and verbal aggressive behaviour had escalated.
The resident's progress notes identified that the resident expressed lack of pain control even though they were still taking the narcotic.
There was further documentation noted in the resident's progress notes identifying the desire to die related to lack of pain control.
The resident's plan of care does identify verbal aggression, however, physical aggression is not included. Interventions and triggers related to the physical aggression were also not included in the plan of care. The resident's plan of care does not include interventions to manage the resident's suicidal verbalization.
The plan of care does not set out clear direction to staff and others who provide direct care to the resident.
[LTCHA 2007, S.O. 2007, c. 8, s. 6.(1)(c)]

6. A resident's admission assessment identified that the resident occasionally refused care. The resident's progress notes were reviewed on February 3/12 and identified that behaviours such as, refusing care, verbal aggression, exit seeking, wandering and inappropriate sexual behaviour had occurred in the nine months since admission. The resident's admission and quarterly assessments showed that these behaviours fluctuated.
The resident's printed plan of care was reviewed on February 2/12.
Inappropriate sexual behaviour was identified on the plan of care, however, the resident's wandering, exit seeking and refusal of care behaviours were not set out in the plan of care.
The resident's plan of care was not revised when the resident's care needs changed.
[LTCHA 2007, S.O. 2007, c. 8, s. 6.(10)(b)]
7. The licensee did not ensure that that there is a written plan of care that sets out clear directions to staff and others who provide direct care to the resident.
A resident's progress notes were reviewed on February 3/12 and identified that the resident had several episodes of agitated behaviour in a period of a month.
The resident's plan of care reviewed by the inspector on February 3/12 did not include agitated behaviours or set out clear direction to manage the resident's agitation.
Specific interventions identified in the resident's progress notes post incident were not included in the resident's plan of care and therefore clear direction was not provided.
[LTCHA 2007, S.O.2007, c.8, s. 6(1)(c)]
8. The licensee did not ensure that the resident's Power Of Attorney/ Substitute Decision-Maker(POA/SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.
A resident's progress notes identified staff's concern related to the resident's toileting assistance and transfers onto the toilet with the hygienic sling.
A referral was sent to the physiotherapist (PT) to assess the resident's upper trunk control.
The resident's progress notes identified that the (PT) was in to assess the resident's sitting and balance ability and changed the resident's plan of care to reflect the resident's newly assessed needs.
It is identified 10 days later in the resident's progress notes that the resident's SDM was upset that the resident's plan of care was changed without the SDM's involvement.
The resident's SDM was not given the opportunity to participate fully in the development and implementation of the resident's plan of care.
[LTCHA 2007, S.O.2007, c.8, s. 6(5)]
9. There were three episodes of a resident exit seeking in the resident's progress notes. In one of these episodes, the resident was found outside.
The resident's plan of care did not include the exit seeking behaviour nor provide direction to staff and others who provide direct care to the resident.
Other behaviours, such as wandering, agitation, refusing baths and verbal aggression were also found documented in the resident's progress notes, however, the plan of care contained no reference to these behaviours and therefore, did not set out clear directions to staff and others who provide direct care to the resident.
[LTCHA 2007, S.O.2007, c.8, s. 6(1)(c)]
10. The licensee did not ensure that a resident's plan of care set out clear directions to staff and others who provide direct care to a resident.
A resident who is dependent on staff for mobility and unable to communicate consent was inappropriately touched sexually by another resident.
The progress notes of the resident who inappropriately touched other residents sexually were reviewed on February 2/11 and the following was documented:
- nine months prior to the above incident, the resident who inappropriately sexually touches other residents was found in the room of the resident involved in the above incident attempting to assist the resident out of bed and also kiss the resident x 3.
- seven and eight months prior to the incident, this resident was observed by staff to inappropriately sexually touch two other residents.
- eighteen days post incident, this resident was observed to attempt to inappropriately touch another resident sexually.
Although, the "Dementia Observation System Records(DOS) documentation were completed by the PSWs, an analysis of the resident who inappropriately touches other residents sexually was not completed and subsequently a plan of care was not developed until after the incident involving the resident who was dependent on staff for mobility and unable to communicate consent, even though the sexual touching/inappropriateness was first identified nine months prior.

An intervention " protect other residents if unable to protect themselves" was identified in the plan of care of the resident who displayed inappropriately sexual touching, however, clear direction to staff and others is not provided.
The inspector identified the above unclear direction to a RPN on February 2/12, who in turn brought this to the attention of the Program Coordinator . An updated plan of care which included clear direction to manage the sexual inappropriateness was then provided to the inspector on February 3/12.
The resident's written plan of care did not set out clear direction to staff and others who provide direct care to the resident.
[LTCHA 2007, S.O. 2007, c. 8, s. 6.(1)(c)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. A resident became angry and was physically aggressive with a Registered staff member when the staff member informed the resident that the narcotic the resident had been receiving was discontinued. The resident's physical and verbal aggressive behaviour had escalated with the home's attempts to manage the resident's pain.
As well. the resident's progress notes identified that the resident had voiced suicidal thoughts.
The resident's plan of care does identify interventions to manage verbal aggression, however, the resident's physical aggression is not included.
Strategies have not been developed or implemented to respond to the resident's physical aggression.
[O. Reg. 79/10, s. 53 (4)(b)]
2. The licensee did not ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours.
A resident's progress notes were reviewed on February 3/12 and identified that the resident had several episodes of agitated behaviour in the a period of a month. The resident's plan of care reviewed by the inspector on February 3/12 did not include agitated behaviours or provide strategies to manage the resident's agitation.
Strategies were not developed or implemented to respond when the resident demonstrated responsive behaviours.
[O. Reg. 79/10, s. 53 (4)(b)]
3. The licensee did not ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours.
A resident's health care record was reviewed on February 2/12 and identified behaviours such as, refusing care, verbal aggression, exit seeking, wandering and inappropriate sexual behaviour which occurred between May/11 and January/12.
The resident's printed plan of care dated December/11 was reviewed on February 2/12. Inappropriate sexual behaviour was identified on the plan of care, however, strategies to manage the resident's wandering, exit seeking and refusal of care behaviours were not developed. The home's policies, " Behaviour Assessment and Interventions and Responsive Behaviours-Management " were reviewed on February 3/12. According to the home's "Behavioural Management Decision – Tree", an observational assessment of the resident's behaviour is done , followed by an analysis of triggers or factors related to the behaviour and resulting in interventions to manage the behaviour.
Although, the "Dementia Observation System Records (DOS)" were documented by the PSWs, an analysis by the nursing staff of the resident's behaviour was not completed and subsequently written strategies and interventions were not developed or implemented.
[O. Reg. 79/10, s. 53 (4)(b)]

Additional Required Actions:

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

WN #3: 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 subsections:

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 did not protect residents from abuse by anyone in the home.
A resident who is dependent on staff for mobility and unable to communicate consent was inappropriately touched sexually by another resident.
The other resident's progress notes were reviewed on February 2/11 and the following was documented:
- nine months prior to the incident, this resident was found in the room of the resident, who was inappropriately sexually touched, three times attempting to assist the resident out of bed and also kiss the resident three times.
- seven and eight months prior to the incident, this resident was observed by staff to inappropriately sexually touch two other residents.
- eighteen days post incident, this resident was observed to attempt to inappropriately touch another resident sexually.
Although, the "Dementia Observation System Records(DOS)documentation was completed by the PSWs, an analysis of the resident who inappropriately touched other residents sexually was not completed and subsequently a plan of care was not developed until after the incident involving the resident who was dependent on staff for mobility and unable to communicate consent, even though the sexual touching/inappropriateness was first identified nine months prior.
An intervention " protect other residents if unable to protect themselves" was identified in the plan of care of the resident who displayed inappropriately sexual touching, however, clear direction to staff and others is not provided.
The inspector identified the above unclear direction to a RPN on February 2/12, who in turn brought this to the attention of the Program Coordinator . An updated plan of care which included clear direction to manage the sexual inappropriateness was then provided to the inspector on February 3/12.
The home did not protect other resident from this resident's sexual inappropriateness despite having knowledge of the sexual behaviour prior to the incident involving the resident who was dependent on staff for mobility and unable to communicate consent.
[LTCHA 2007, S.O. 2007, c. 8, 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 ensuring all residents are protected from abuse by anyone in the home, to be implemented voluntarily.

WN #4: 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 subsections:

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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. A resident's plan of care identified that assistance of two staff and a mechanical lift and sling is required for transfers. A Critical Incident was reported to the MOHLTC which identified that a PSW placed a transfer sling under the resident who was sitting in a wheel chair and connected the sling to the ceiling lift. The PSW left the resident to find another staff member to assist with the transfer. The resident was left in this position for approximately an hour as the staff member waited for other staff to return from their break.
The home did not ensure that the home's policy, Abuse: Resident Abuse/Mistreatment was complied with.
[LTCHA 2007, S.O. 2007, c. 8, s. 20.(1)]
2. The home identified on another critical incident that a resident reported to the Program Coordinator that a PSW was verbally abusive.
There were documented statements of verbal abuse written by the above PSW in the resident's progress notes.
The home did not ensure that the home's policy, Abuse: Resident Abuse/Mistreatment was complied with.
[LTCHA 2007, S.O. 2007, c. 8, s. 20.(1)]
3. The licensee's policy to promote zero tolerance of abuse and neglect of residents,reviewed on February 3/12 does not set out consequences for those who abuse or neglect residents.
Item 5.5 of the home's policy identifies the direction that the home or a member of a Regulated health profession takes when sexual abuse is reasonably believed, however, there is no indication of reporting other types of abuse.
The home's policy summary only identifies that an investigation of residents' complaints could result in several different consequences. The policy does not indicate consequences related to those who abuse or neglect residents.
[LTCHA 2007, S.O. 2007, c. 8, s. 20.(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 ensuring that ensure that the home's policy, Abuse: Resident Abuse/Mistreatment is complied with and that the policy sets out consequences for those who abuse or neglect residents and clearly sets out what constitutes abuse, to be implemented voluntarily.

WN #5: 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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The home identified on a (CI) critical incident which was reported to the MOHLTC, that a resident reported to the Program Coordinator that a PSW was verbally abusive.
The incident was reported to the Director four months later.
The home failed to report the incident of abuse immediately to the Director.
[LTCHA 2007, S.O. 2007, c. 8, 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 ensuring that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion to the Director; improper or incompetent treatment or care of a resident, and abuse of a resident by anyone or neglect of a resident by the licensee or staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The home's policy, " Abuse: Resident Abuse/Mistreatment" was reviewed on February 6/12.
The policy fails to identify measures or strategies to prevent abuse.
[O. Reg. 79/10, s. 96 (c)]
2. The home's written policy to promote zero tolerance of abuse and neglect of residents did not contain procedures and interventions to assist and support residents who have been abused.
A resident who is dependent on staff for mobility and unable to communicate consent was inappropriately touched sexually by another resident.
The progress notes of the resident who was inappropriately touched sexually identified that the resident's family member requested the home arrange "counselling".
The home's policy, "Abuse: Resident Abuse/Mistreatment", was reviewed on February 6/12. The policy fails to identify procedures and interventions to assist and support residents who have been abused.
[O. Reg. 79/10, s. 96 (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home's policy, Abuse: Resident Abuse/Mistreatment identifies measures and strategies to prevent abuse and contain procedures and interventions to assist and support residents who have been abused, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

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. A resident's Substitute Decision Maker was not immediately notified of a witnessed incident of abuse.
A resident, who is dependent on staff for mobility and unable to communicate consent was inappropriately touched sexually by another resident.
A RN documented that the resident's Power of Attorney/Substitute Decision Maker (POA/SDM) was not informed immediately of the above incident.
The critical incident submitted to the Ministry of Health and Long Term Care (MOHLTC) identified that the Medical Director advised that the family of the resident, who was touched inappropriately, not be informed until the next day, however, this direction was not found to be documented.
The home did not inform the SDM involved in this incident immediately.
[O Reg 79/10, s. 97. (1)(a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that resident's Substitute Decision Makers are immediately notified upon becoming aware of a witnessed incident of abuse of a resident that could be detrimental to a resident's health or well being, to be implemented voluntarily.

Issued on this 21st day of March, 2012

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