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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2013	2012_205129_0004	H-002161-12	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

RIDGEVIEW
385 HIGHLAND ROAD WEST, STONEY CREEK, ON, L8J-3X9

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 19, 21, 22, December 4 & 5, 2012

During the course of the inspection, the inspector(s) spoke with residents, registered and unregulated nursing staff, the Minimum Data Set Coordinator, the Director of Care and the Administrator in relation to Log #H-002161-12

During the course of the inspection, the inspector(s) conducted a tour of the home, observed residents, reviewed clinical records as well as the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Pain

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, in relation to the following: [6(2)]

a) Resident #2 was not assessed and the plan of care was not based on the resident's needs related to pain and pain management. Documentation in resident #2's clinical record indicated that the resident complained of pain from two sources. Staff documented that as necessary medication was provided to the resident 8 times in July 2012 and 8 times in August 2012 in order to respond to the resident's complaints of pain. Data collected during Minimum Data Set (MDS) review completed in July 2012 indicated that the resident has mild pain less than daily from joint and other sources and the following review completed in October 2012 indicated that the resident's pain had increased to a moderate level. Staff and the clinical record confirmed that an assessment of the resident's pain was not completed.
b) Resident # 6 was not assessed and the plan of care was not based on the needs of the resident related to a medical disorder. Documentation in the clinical record indicated that the resident experienced medical events related to this disorder in June 2012, October 2012 and in November 2012. A family contacted staff in October 2012 to express concern for the resident's health related these medical events. Staff and the clinical record confirmed that an assessment of the risks to the resident related to these medical events was not completed.
c) Resident # 4 was not assessed and the plan of care was not based on the resident's need for safety related to the use of side rails. Documentation in the clinical record indicated that the resident was at risk for falling and interventions in place included the use of two bed side rails whenever the resident was in bed as well as the use of bed and chair alarms. It was noted that in July 2012 the resident was found standing on one leg at the side of the bed with the other leg wedged in one side rail that was in the up position. Staff and the clinical record confirmed that the resident was not assessed in relation to the safe use of side rails either prior to or following this incident and the care set out in the plan of care continued to contain directions that 2 side rails were to be used when the resident was in bed, as a falls prevention strategy following this incident.
d) Resident #3 was not assessed and the plan of care was not based on the residents needs related to pain and pain management. Documentation in the clinical record indicated that over a 46 day period in October and November 2012 the resident complained of pain 18 times for which both regularly scheduled narcotic analgesics and non narcotic analgesics were administered. The sources of the pain identified in

the clinical record were the abdomen and unspecified sources. Staff and the clinical record confirmed that there was not an assessment of pain completed. [s. 6. (2)]

2. The licensee did not ensure that all residents were reassessed and the plan of care reviewed and revised when care set out in the plan of care has not been effective, in relation to the following: [6(10)(c))
a)Minimum Data Set (MDS) assessments completed in April, July, and October 2012 for resident # 3 indicated that ten identified indicators of poor mood had not changed over the course of this 12 month period of time. Registered staff confirmed that the data collected on these assessments would indicate that the care goals established for this resident were not being met and the care set out in the plan had not been effective. Clinical documentation confirmed that the plan of care was not reviewed or revised over this period of time when the care set out was not effective.
Behavioural data collected on the same assessments for this resident indicated that 4 identified behaviours had also not changed over the 12 month period of time. Registered staff confirmed that care goals established for this resident were not being met and the care set out in the plan was not effective. Clinical documentation confirmed that the plan of care was not reviewed or revised over this period of time when the care set out was not effective.
b) MDS assessments completed in July and October 2012 for resident #6 indicated that 4 identified expressions of poor mood being demonstrated by the resident had not changed over the course of this 9 month period of time. Registered staff confirmed that the data collected on these assessments would indicate that care goals established for this resident were not being met and the care set out in the plan had not been effective. Clinical documentation confirmed that the plan of care was not reviewed or revised over this period of time when care set out in the plan was not effective.
Behavioural data collected on the same assessments for this resident indicated that 4 identified responsive behaviours being demonstrated by this resident had not changed over this 9 month period of time. Registered staff confirmed that the data collected would indicate that the care goals established for this resident where not being met and the care set out in the plan was not effective. Clinical documentation confirmed that the plan of care was not reviewed or revised over this period of time when care set out in the plan was not effective.
c) MDS assessments completed in April, July and October 2012 for resident #5 indicated that 4 identified expressions of poor mood being demonstrated by the resident had not changed over the course of this 12 month period of time. Registered

staff confirmed that the data collected on these assessments would indicate that care goals established for this resident were not being met and the care set out in the plan had not been effective. Clinical documentation confirmed that the plan of care was not reviewed or revised over this period of time when care set out in the plan was not effective.
Behavioural data collected on the same assessments for this resident indicated that 4 responsive behaviours being demonstrated by the resident had not changed over this 12 month period. Registered staff confirmed that data collected on these assessments would indicated that care goals established for this resident were not being met and the care set out in the plan had not been effective. Clinical documentation confirmed that the plan of care was not reviewed or revised over this period of time when the care set out in the plan was not effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 003 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. 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure the plan of care was based on, at a minimum, interdisciplinary assessment of mood and behaviour patterns, including wandering, any identified responsive behaviours , any potential behavioural triggers and variations in resident function at different times of the day in relation to the following: [26(3)5]

a) The plan of care for resident #2 indicated the resident suffers from alterations in mood state. At the time of this inspection there was no indication in the documented clinical record that an interdisciplinary assessment was conducted in relation to this resident's mood. Registered staff confirmed that they had not participated in an interdisciplinary assessment of issues related to mood for this resident. It is identified on the care plan that this resident also demonstrated responsive behaviours; however there was no evidence in the resident's clinical record that an assessment of these behaviours had occurred and registered staff confirmed that there had not been an interdisciplinary assessment related to the potential triggers for the responsive behaviours being demonstrated by this resident.

b) The clinical record for resident #6 indicated the resident demonstrated responsive behaviours towards co-residents; however there was no evidence in the resident's clinical record that an assessment of these behaviours had occurred and registered staff confirmed that there had not been an interdisciplinary assessment related to the potential triggers for the responsive behaviours being demonstrated by this resident.

c) The clinical record for resident #5 indicated the resident demonstrated responsive behaviours towards co-residents; however there was no evidence in the resident's clinical record that an assessment of these behaviours had occurred and registered staff confirmed that there had not been an interdisciplinary assessment related to potential triggers for the responsive behaviours being demonstrated by this resident. [s. 26. (3) 5.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol or procedure, that the plan, policy, protocol or procedure was complied with, in relation to the following: [8(1)(b)]
Staff in the home did not comply with the home's policy [Restraints-Overview #LTC-AA-20 dated July 2010] for resident #4. This policy defines restraint as a device that restricts a residents freedom to act, move or access an area and directs that a restraint may be used only when a formal written assessment of a resident's needs has been completed and all other alternate modes of treatment and/or interventions have been explored, tried and have failed.
The care plan for resident #4 identified the resident as a high risk for falls because the resident attempts to get out of bed and one of the interventions to manage this risk directs staff to ensure two side rails are up when in bed for safety. Staff identified that the side rails are being used to prevent the resident from leaving the bed and also confirmed that a formal written assessment of the need for the restraint and the effective and safe implementation of the side rails was not completed. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that were the Act or this Regulation requires the licensee to a long-term care home to have, institute or otherwise put in place any plan, policy, protocol or procedure, that the plan, policy, protocol or procedure is complied with, 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. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee did not ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours , whether cognitive, emotional, social, environmental or others where developed to meet the needs of residents with responsive behaviours, in relation to the following: [53(1)1]
In response to a request to provide policies, procedures and practises related to the management of responsive behaviours, the home provided the following documents: [Management of Aggressive Resident Behaviour # LTC-P-110 dated September 2001, Dementia and Behavioural Guidelines – Assessing Delirium – no reference number or date and Workplace Violence and Aggression Management # HS18-0-10 revised date June 2012]. A review of these documents indicated that they did not contain written approaches to care, screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours. At the time of this inspection the Administrator was unable to provide any documents that contained these requirements. [s. 53. (1) 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 and ensuring that there are written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours to meet the needs of the residents with responsive behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee did not ensure that drugs were stored in an area or medication cart that is secure and locked, in relation to the following: [129(1)(a)(ii)]
It was noted during a tour of a resident home area on November 22, 2012 at 1414hrs. that the medication room door was open, an unlocked medication cart was in the medication room and there were no registered staff in the area. This medication room is visible to residents, visitors and others walking in the main hall of this home area and could have been accessed by persons other than registered staff. [s. 129. (1) (a) (ii)]

Ontario

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

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Issued on this 21st day of February, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Phyllis Hiltz-Bontje

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2012_205129_0004
Log No. / Registre no:	H-002161-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 19, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	RIDGEVIEW 385 HIGHLAND ROAD WEST, STONEY CREEK, ON, L8J-3X9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANNE D'AMBROSIO

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall reassess the effectiveness of care related to responsive behaviours for residents #2, #6 and #5 and review and/or revise the plan of care for these residents based on that reassessment. The licensee shall also prepare, submit and implement a plan to ensure that whenever a reassessment of a resident indicates that the care set out in the plan has not been effective in meeting the needs of the residents, that the plan of care is reviewed and/or revised as necessary. The plan is to be submitted on or before March 13, 2013 to Phyllis Hiltz-Bontje by mail at Hamilton Service Area Office, 119 King Street West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by email at Phyllis.HiltzBontje@Ontario.ca.

Grounds / Motifs :

1. Three of three residents demonstrating responsive behaviours did not have the plan of care reviewed or revised when a reassessment of the resident indicated that the care set out in the plan of care was not effective.
a) Minimum Data Set (MDS) assessments conducted in April, July and October 2012 for resident # 2 indicated that ten identified indicators of poor mood had not changed over the course of a 12 month period. Registered staff confirmed that the data collected on these assessments would indicate that the care goals established for this resident were not being met and the care set out in the plan had not been effective. Clinical documentation confirmed that the plan of care was not reviewed or revised over this period of time when the care set out was

not effective.
Behavioural data collected on the same assessments for this resident indicated that 4 identified behaviours had also not changed over this 12 month period of time. Registered staff confirmed that care goals established for this resident were not being met and the care set out in the plan had not effective. Clinical documentation confirmed that the plan of care was not reviewed or revised over this period of time when the care set out was not effective.
b) MDS assessments completed in July and October 2012 for resident #6 indicated that 4 identified expressions of poor mood being demonstrated by the resident had not changed over the course of a 9 month period of time.
Registered staff confirmed that the data collected on these assessments would indicate that care goals established for this resident were not being met and the care set out in the plan had not been effective. Clinical documentation confirmed that the plan of care was not reviewed or revised over this period of time when care set out in the plan was not effective.
Behavioural data collected on the same assessments for this resident indicated that 4 identified responsive behaviours being demonstrated by this resident had not changed over this 9 month period of time. Registered staff confirmed that the data collected would indicate that the care goals established for this resident were not being met and the care set out in the plan was not effective. Clinical documentation confirmed that the plan of care was not reviewed or revised over this period of time when care set out in the plan was not effective.
Over this period of time the resident continued to demonstrate responsive behaviours that caused injury to and frightened co-residents.
c) MDS assessments completed in April, July and October 2012 for resident #5 indicated that 4 identified expressions of poor mood being demonstrated by the resident had not changed over the course of this 12 month period of time.
Registered staff confirmed that the data collected on these assessments would indicate that care goals established for this resident were not being met and the care set out in the plan had not been effective. Clinical documentation confirmed that the plan of care was not reviewed or revised over this period of time when care set out in the plan was not effective.
Behavioural data collected on the same assessments for this resident indicated that 4 responsive behaviours being demonstrated by the resident had not changed over this 12 month period. Registered staff confirmed that data collected on these assessments would indicated that care goals established for this resident were not being met and the care set out in the plan had not been effective. Clinical documentation confirmed that the plan of care was not

reviewed or revised over this period of time when the care set out in the plan was not effective. Over this period of time the resident continued to demonstrate responsive behaviours that caused injury to and frightened co-residents. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall conduct and document interdisciplinary assessments for resident #2, #6 and #5 in relation to mood and behaviour patterns, including wandering, any identified responsive behaviours and any potential behavioural triggers and variations in the residents function at different times of the day. The licensee shall also prepare, submit and implement a plan to ensure that all residents who are demonstrating responsive behaviours have a documented interdisciplinary assessment related to mood and behaviour patterns. The plan is to be submitted on or before March 13, 2013 to, Phyllis Hiltz-Bontje by mail at Hamilton Services Area Office, 119 King Street West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by email at Phyllis.HiltzBontje@Ontario.ca.

Grounds / Motifs :

1. Previously issued non compliant as a compliance order on March 7, 2011.
2. Three of three residents reviewed who where demonstrating alterations in mood and responsive behaviours did not have interdisciplinary assessment related to these identified needs.
a) The plan of care for resident #2 indicated the resident demonstrated alterations in mood state. At the time of this inspection there was no indication in the documented clinical record that an interdisciplinary assessment had been conducted in relation to this resident's mood. Registered staff confirmed that they had not participated in an interdisciplinary assessment of issues related to mood for this resident. It is identified on the care plan that this resident also demonstrates responsive behaviours including, verbal aggression and social inappropriate behaviours. There was no evidence in the resident's clinical record that an interdisciplinary assessment of these behaviours had been completed and registered staff confirmed that they did not participate in an interdisciplinary assessment related to the potential triggers for the responsive behaviours being demonstrated by this resident.
b) The clinical record for resident #6 indicated the resident demonstrated responsive behaviours towards co-residents; however there was no evidence in the resident's clinical record that an interdisciplinary assessment of these behaviours had occurred and registered staff confirmed that they have not participated in an interdisciplinary assessment related to the potential triggers for the responsive behaviours being demonstrated by this resident.
c) The clinical record for resident #5 indicated the resident demonstrated responsive behaviours towards co-residents; however there was no evidence in the resident's clinical record that an assessment of these behaviours had occurred and registered staff confirmed that they have not participated in an interdisciplinary assessment related to potential triggers for the responsive behaviours being demonstrated by this resident. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee shall assess resident #2 in relation to pain and pain management, resident #6 in relation to safety related to a seizure disorder, resident #4 in relation to the safe use of side rails and resident #3 in relation to pain and pain management. The licensee shall also prepare, submit and implement a plan to ensure the care set out in the plan of care for each resident is based on an assessment of the resident and the identified needs and preferences of the resident. The plan is to be submitted on or before March 13, 2013 to Phyllis Hiltz-Bontje by mail at Hamilton Service Area Office, 119 King Street West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by email at Phyllis.HiltzBontje@Ontario.ca

Grounds / Motifs :

1. Previously identified non compliant as a compliance order on March 7, 2011.
2. Four of four residents reviewed were not assessed and the plan of care was not based on the resident's needs, in relation to the following:
a) Resident #2 was not assessed and the plan of care was not based on the resident's needs related to pain management. Documentation in resident #2's clinical record indicated that the resident complained of pain from two sources. Staff documented that as necessary medication was provided to the resident 8 times in July 2012 and 8 times in August 2012 in order to respond to the resident's complaints of pain. Data collected during Minimum Data Set review completed in July 2012 indicated that the resident had mild pain less than daily from joint and other sources and the following review completed in October 2012 indicated that the resident's pain had increased to a moderate level. Staff and the clinical record confirmed that an assessment of the resident's pain was not completed.
b) Resident # 6 was not assessed and the plan of care was not based on the

needs of the resident related to a medical disorder. Documentation in the clinical record indicated that the resident experienced medical events related to this disorder in June, October and November 2012. A family member contacted staff in the home to express her concern for the resident's health related to these medical events in October 2012. Staff and the clinical record confirmed that an assessment of the risks to the resident related to this medical condition was not completed.

c) Resident # 4 was not assessed and the plan of care was not based on the resident's needs for safety related to the use of side rails. Documentation in the clinical record indicated that the resident was at risk for falling and interventions had been put in place that included the use of two side rails whenever the resident was in bed as well as alarms, while both in bed and sitting in the chair. It was noted that in July 2012 the resident was found standing on one leg at the side of the bed with the other leg wedged in one of the side rails that was in the up position. Staff and clinical documentation confirmed that the resident was not assessed in relation to the safe use of side rails either prior to or following this incident and that the plan of care continued to contained directions for staff that 2 side rails were to be used when the resident was in bed as a falls prevention strategy following this incident.

d) Resident #3 was not assessed and the plan of was not based on the need for pain management identified by the resident. Documentation in the clinical record indicated that over a 46 day period between October and November 2012 the resident complained of pain 18 times for which both regularly scheduled narcotic analgesic and non narcotic analgesics were administered. The sources of pain identified in the clinical record were the abdomen and unspecified sources. Staff and the clinical documentation indicated there was not an assessment of pain for this resident and the plan of care did not identify a need for pain management for this residents. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2013

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 19th day of February, 2013

Signature of Inspector / Signature de l'inspecteur : Phyllis Hiltz-Bontje

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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