Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2019	2019_740621_0034	019343-19, 021048-19	Critical Incident System

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Roberta Place
503 Essa Road BARRIE ON L4N 9E4

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

JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 18 - 22, 2019.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:
-One intake related to a critical incident, involving a resident; and
-One intake related to responsive behavior management.

During the course of the inspection, the inspector(s) spoke with the Regional Director of Long Term Care, Regional Services Coordinator, Regional Manager of an external agency, Administrator, Director of Care (DOC), Staff Educator, Culinary Manager, Registered Dietitian (NM), a Dietary Aide, a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was complied with, in respect to the nutrition care, hydration and dietary services program required under section 11 of the Act: 1. That there was a written description of the program that included its goals, objectives and relevant policies, procedures and protocols, and provided for methods to reduce the risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required; and 4. The licensee kept a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A Critical Incident System (CIS) report was submitted to the Director on October 31, 2019, regarding an incident involving resident #001.

During a review of the home's investigation notes, Inspector #621 identified a specific

number of policies from a certain program, with revision dates greater than one year. On further review, the Inspector also noted the following:

a) One specific policy identified that Community Care Access Service (CCAC) was the organization to be contacted to obtain professional service to complete a certain type of assessment; and that in most communities the specified professional worked for the CCAC; and

b) A specific number of other policies, referenced specified types of evidence from other provincial health organizations, and/or were dated from up to nineteen years ago.

During an interview with the Administrator, they reported to the Inspector that if the home required a specific health care professional to complete a specified assessment of a resident, they would make a referral to the Local Health Integration Network (LHIN), which was the agency that the home accessed a specific type of consultation service. The Administrator confirmed that the said service was no longer accessed through CCAC.

During an interview with a Manager, they reported to the Inspector that they were not involved in annual reviews of specific program policies; that these reviews were completed at a corporate level; and that they were not aware of what evidence supported a specific type of evidence that was referenced in one of the policies identified. When the Inspector inquired as to where a certain number and specific type of supporting documents could be found in the home, the Manager was unsure, but would follow up. During the subsequent day of inspection, the Manager provided a copy of a training program guide from another provincial health service agency with a date inconsistent with the documents cited within a specific policy. Later that day, the Manager also informed the Inspector that they had located a specific manual that was cited within the identified policy, which was located in another area of the home. Additionally, a certain number of other references that were cited in the said policy, were not located at the time of inspection.

During an interview with a specific member of the home's staff, they reported to the Inspector that they had not been involved in an annual review of policies for the of specified program since their hire in late summer of 2018.

During an interview with the Regional Manager of an external agency, they reported that they were responsible for a specific service provided in the home; that they had just

started in their position within the past month; and could not answer the Inspectors query as to when the program they were responsible for, was last reviewed.

Inspector #621 reviewed a copy of the licensee's corporate policy titled "Operations – Corporate Policy Acceptance", effective 2018-07-01, which identified that on May 31, 2019, the Director of Long Term Care Operations, signed off to confirm that all Jarlette Health Services policies and procedures were established in accordance with set legislation, where applicable, including but not limited to the Long Term Care Homes Act; S.O. 2007; and all such policies and procedures in all Jarlette Health Services manuals had been reviewed by the owner of the policy and represented the current practice and standards.

During an interview with the Director of Long Term Care Operations, they reported to the Inspector that the Regional Manager of an external agency was the owner of the identified program policies and procedures, and thus responsible for the content of those policies; that policies which were reviewed but had not changed, would not have a change to their "revision date" unless there was an update to the policy; and that the policies of the specified program, were in fact discussed during the past year, but that there was no written record of the evaluation to their knowledge. In a subsequent interview with the Director of Long Term Care Operations, they confirmed that they did not have written evidence to support that a review of the specified program in 2018 or 2019 had been completed by the home, and that the home's management team, a specific Manager and a specific member of the staff, should have been involved in the annual program review.

During a final interview with a specific Manager and the home's Administrator, Inspector #621 inquired as to whether the home had a written description of the specified program, as required in Ontario Regulation 79/10, s.30(1)1. The Administrator followed up on the Inspector's inquiry and confirmed on the final day of inspection that the home did not have a written description of the program. [s. 30. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the responses to interventions were documented.

A Critical Incident System (CIS) report was submitted to the Director on particular date in October 2019, involving a resident-to-resident altercation between resident #002 and #003 one day earlier. The CIS report also identified that both residents were placed on a specific assessment intervention.

During separate interviews with RPNs #117 and #118 and PSW #119, they reported to Inspector #621 that residents #002 and #003 both had responsive behaviours and were started on the assessment intervention, following the October 2019 incident. RPN #119 and PSW #119 confirmed that resident #002 and #003's assessment forms were to be completed between two specified dates in October 2019; were to be completed at required time intervals during the observation period; and could be initiated at any time on request of the Behavioral Support Ontario (BSO) team, and/or at the direction of the RPN or RN, to more closely assess the residents behaviours. RPNs #117 and #118 further reported that PSWs were responsible for monitoring and completing required documentation on the assessment form, and that the registered staff, including the unit RPNs and RNs were responsible for ensuring that the assessment was documented in full at the end of each shift.

During a review of the specified assessment intervention forms, Inspector #621 identified

missing documentation not only on the assessment records for resident #002 and #003, but also for resident's #007, #008 and #009, for specified dates and times.

During a review of resident #002, #003, #007, #008 and #009's assessment records with Inspector #621, RPN's #117 and #118 confirmed during separate interviews, that assessment charting had gaps of missing documentation in the areas identified, and therefore had not been completed in their entirety, as required.

During an interview with the DOC, they reported to the Inspector that when heightened monitoring of residents with responsive behaviours was requested by the BSO Mobile Support team and/or the home's registered nursing staff, it was expected that the unit RPNs and PSWs worked together to ensure accurate and complete documentation occurred on the assessment intervention form. Additionally, the DOC reported that it was their expectation that the RPN on duty, reviewed and ensured the full completion of the assessment record for each identified resident, prior to the end of their shift. The DOC confirmed that the CIS report provided to the Director on a specified date in October 2019, had identified that both resident #002 and #003 were placed on assessment intervention following the specified incident, to aid in further assessment of both resident's responsive behaviours. Additionally, the DOC reviewed and confirmed that the assessment records for residents #002 and #003, as well as resident's #007, #008 and #009, for the dates and times as indicated, were not completed in full, as required. [s. 53. (4) (c)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were reassessed and the plan of care reviewed and revised at least every six months, and at any other time when, the residents care needs changed, or care set out in the plan was no longer necessary; or care set out in the plan was not effective.

A Critical Incident System (CIS) report was submitted to the Director on a specific date in October 2019, involving a resident-to-resident altercation between resident #002 and #003 one day earlier. The CIS report stated that there had been a previous altercation with injury between these two residents in the spring of 2019, and that both residents had specific types of responsive behaviours. Lastly, the CIS report identified that resident #002's substitute decision maker (SDM) suggested a specific type of strategy, to help reduce a specific responsive behaviour.

During interviews with PSW's #110, #115, and #119, as well as RPN's #117 and #118, they reported to Inspector #621, that resident #002 had a specific type of responsive behaviour, and found that only a specific number and type of strategies effective to reduce resident #002's specified behaviour. PSW #110 and #119 also identified that they utilized a further type of strategy recommended by the resident's SDM, at a particular time of day, when the resident was most receptive to being in a certain area of the home.

During the inspection, Inspector #621 reviewed resident #002 and #003's most current responsive behaviours care plans and found no information in resident #002's care plan to identify use of the SDM's suggested strategy at a certain time of day and in a certain location of the home. Further, under a specific care plan focus, it identified the resident possessed a certain mobility aide, and that the resident may use the aide inappropriately, when responsive behaviours were active.

During a review of resident #002' care plan with the Inspector, PSW #110, and RPN's #117 and #118, reported that the resident no longer possessed the identified mobility aide, and that the care plan also did not identify the use of the SDM's suggested strategy with the resident during a particular care activity, during a certain time of day, and should have.

With regards to resident #003, PSW's #110 and #119, as well as RPN's #117 and #118, reported during separate interviews to the Inspector, that resident #003 had specific types of responsive behaviours, and that strategies including the use of a certain type of device, as well as a specified communication tool, had been ineffective and no longer in use. It was also reported that resident #002 and #003 had been in a previous altercation in the spring of 2019, and subsequently, resident #003 had been referred to Behavioural Support Ontario (BSO) for assessment, as of a specified date in October 2019.

During an observation, as well as a review of the resident's most current behavior care plan, Inspector #621 identified discrepancies including: more than one care plan with a specific responsive behavior focus, with information duplicating itself in each, and an intervention which identified that staff were to ensure that resident #003 was able to operate a specific device. Additionally, there continued to be an intervention which identified that staff were to use a specific communication tool, when expressing certain behaviours. Finally, in the behavior care plans for this resident, it continued to identify a BSO referral from a certain date in the spring of 2019, but made no reference to a more recent referral in October 2019.

During a review of resident #003's most current care plan, PSW #119, as well as RPN's #117 and #118, confirmed with the Inspector that resident #003's behaviour care plan had not been revised to reflect the resident current care needs, with respect to the redundancy of having more than one behavior care plans for the same focus; documentation of a previous BSO referral, but not the most current one; reference to the use of a specific device; and reference to a certain communication tool, which PSWs reported was no longer being used.

During an interview with the DOC, they reported to the Inspector that it was their expectation that when a resident's care needs changed and strategies within the care plan were no longer current or effective, that RPN/RN staff updated the care plans immediately with the most current information. The DOC also identified that they also expected that there was ongoing inter-collaborative communication between unit staff

regarding the currency and accuracy of information in resident care plans. On review of resident #002 and #003's most current responsive behavior care plans, the DOC confirmed to the Inspector that at the time of inspection, both resident's care plans contained strategies that were no longer in use or effective, and as a consequence, the responsive behavior care plans did not reflect each resident's most current care needs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are reassessed and the plan of care is reviewed and revised at least every six months, and at any other time when, the residents care needs change, or care set out in the plan is no longer necessary; or care set out in the plan is not effective, to be implemented voluntarily.

Issued on this 27th day of November, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2019_740621_0034
Log No. / No de registre :	019343-19, 021048-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 26, 2019
Licensee / Titulaire de permis :	Barrie Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Roberta Place 503 Essa Road, BARRIE, ON, L4N-9E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	James Abraham

To Barrie Long Term Care Centre 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

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee must be compliant with Ontario Regulation 79/10, s.30(1).

Specifically, the licensee must:

a) Develop and implement a written description of a specific program, which includes the program goals, objectives, relevant policies, procedures and protocols, and methods to reduce risk and monitor outcomes, including protocols for referral of residents to specialize resources where required;

b) Ensure that the specific program is reviewed annually, and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

c) Ensure that home's staff, including, but not limited to, a specific Manager and a specific member of the staff, are knowledgeable of and have ready access to the specific program's policies and procedures;

d) Ensure that evidence cited within the specific program policies and procedures, is readily accessible within the home; and

e) Ensure that there is a written record of each annual review of the specific program, including documentation to identify who participated in the review, when the review was completed, a summary of any changes made, and the date those changes were implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that the following was complied with, in respect to the nutrition care, hydration and dietary services program required under section 11 of the Act: 1. That there was a written description of the program that included its goals, objectives and relevant policies, procedures and protocols, and provided for methods to reduce the risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required; and 4. The licensee kept a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A Critical Incident System (CIS) report was submitted to the Director on October 31, 2019, regarding an incident involving resident #001.

During a review of the home's investigation notes, Inspector #621 identified a specific number of policies from a certain program, with revision dates greater than one year. On further review, the Inspector also noted the following:

a) One specific policy identified that Community Care Access Service (CCAC) was the organization to be contacted to obtain professional service to complete a certain type of assessment; and that in most communities the specified professional worked for the CCAC; and

b) A specific number of other policies, referenced specified types of evidence from other provincial health organizations, and/or were dated from up to nineteen years ago.

During an interview with the Administrator, they reported to the Inspector that if the home required a specific health care professional to complete a specified assessment of a resident, they would make a referral to the Local Health Integration Network (LHIN), which was the agency that the home accessed a specific type of consultation service. The Administrator confirmed that the said service was no longer accessed through CCAC.

During an interview with a Manager, they reported to the Inspector that they were not involved in annual reviews of specific program policies; that these reviews were completed at a corporate level; and that they were not aware of what evidence supported a specific type of evidence that was referenced in one of the policies identified. When the Inspector inquired as to where a certain number and specific type of supporting documents could be found in the home, the Manager was unsure, but would follow up. During the subsequent day of inspection, the Manager provided a copy of a training program guide from another provincial health service agency with a date inconsistent with the documents cited within a specific policy. Later that day, the Manager also informed the Inspector that they had located a specific manual that was cited within the identified policy, which was located in another area of the home. Additionally, a certain number of other references that were cited in the said policy, were not located at the time of inspection.

During an interview with a specific member of the home's staff, they reported to the Inspector that they had not been involved in an annual review of policies for the of specified program since their hire in late summer of 2018.

During an interview with the Regional Manager of an external agency, they reported that they were responsible for a specific service provided in the home; that they had just started in their position within the past month; and could not answer the Inspectors query as to when the program they were responsible for, was last reviewed.

Inspector #621 reviewed a copy of the licensee's corporate policy titled "Operations – Corporate Policy Acceptance", effective 2018-07-01, which identified that on May 31, 2019, the Director of Long Term Care Operations, signed off to confirm that all Jarlette Health Services policies and procedures were established in accordance with set legislation, where applicable, including but not limited to the Long Term Care Homes Act; S.O. 2007; and all such policies and procedures in all Jarlette Health Services manuals had been reviewed by the owner of the policy and represented the current practice and standards.

During an interview with the Director of Long Term Care Operations, they reported to the Inspector that the Regional Manager of an external agency was the owner of the identified program policies and procedures, and thus responsible for the content of those policies; that policies which were reviewed but had not changed, would not have a change to their "revision date" unless there was an update to the policy; and that the policies of the specified program, were in fact discussed during the past year, but that there was no written record of the evaluation to their knowledge. In a subsequent interview with the Director of Long Term Care Operations, they confirmed that they did not have written evidence to support that a review of the specified program in 2018 or 2019 had been completed by the home, and that the home's management team, a specific Manager and a specific member of the staff, should have been involved in the annual program review.

During a final interview with a specific Manager and the home's Administrator, Inspector #621 inquired as to whether the home had a written description of the

specified program, as required in Ontario Regulation 79/10, s.30(1)1. The Administrator followed up on the Inspector's inquiry and confirmed on the final day of inspection that the home did not have a written description of the program.

The severity of the non-compliance was determined to be a level two, as there was minimal risk of harm to residents. The scope of the issue was a level three, as the lack of a written description of the specific program, and lack of evidence of an annual evaluation of the program had the potential to affect all residents of the home. The home had a compliance history of one or more non-compliances, none of which were the same subsections. (621)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020

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

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)

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 must be compliant with Ontario Regulation 79/10, s. 53 (4).

Specifically, the licensee must also:

a) Develop and implement a process to ensure that staff are completing a specific assessment intervention; and

b) Develop and conduct audits to ensure that the assessment intervention documentation is being completed as required, and maintain a record of the audits that are conducted.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the responses to interventions were documented.

A Critical Incident System (CIS) report was submitted to the Director on particular date in October 2019, involving a resident-to-resident altercation between resident #002 and #003 one day earlier. The CIS report also identified that both residents were placed on a specific assessment intervention.

During separate interviews with RPNs #117 and #118 and PSW #119, they reported to Inspector #621 that residents #002 and #003 both had responsive behaviours and were started on the assessment intervention, following the October 2019 incident. RPN #119 and PSW #119 confirmed that resident #002 and #003's assessment forms were to be completed between two specified dates in October 2019; were to be completed at required time intervals during the observation period; and could be initiated at any time on request of the Behavioral Support Ontario (BSO) team, and/or at the direction of the RPN or RN, to more closely assess the residents behaviours. RPNs #117 and #118 further reported that PSWs were responsible for monitoring and completing required documentation on the assessment form, and that the registered staff, including the unit RPNs and RNs were responsible for ensuring that the assessment was documented in full at the end of each shift.

During a review of the specified assessment intervention forms, Inspector #621 identified missing documentation not only on the assessment records for resident #002 and #003, but also for resident's #007, #008 and #009, for specified dates and times.

During a review of resident #002, #003, #007, #008 and #009's assessment records with Inspector #621, RPN's #117 and #118 confirmed during separate interviews, that assessment charting had gaps of missing documentation in the areas identified, and therefore had not been completed in their entirety, as required.

During an interview with the DOC, they reported to the Inspector that when heightened monitoring of residents with responsive behaviours was requested by the BSO Mobile Support team and/or the home's registered nursing staff, it was expected that the unit RPNs and PSWs worked together to ensure accurate and complete documentation occurred on the assessment intervention form. Additionally, the DOC reported that it was their expectation that the RPN on duty, reviewed and ensured the full completion of the assessment record for each identified resident, prior to the end of their shift. The DOC confirmed that the CIS report provided to the Director on a specified date in October 2019, had identified that both resident #002 and #003 were placed on assessment intervention following the specified incident, to aid in further assessment of both resident's responsive behaviours. Additionally, the DOC reviewed and confirmed

that the assessment records for residents #002 and #003, as well as resident's #007, #008 and #009, for the dates and times as indicated, were not completed in full, as required.

The severity of the non-compliance was determined to be a level two, as there was minimal risk of harm to residents. The scope of the issues was a level three, as incomplete assessment documentation was identified for five out of five (or 100 per cent) of the specific assessment records inspected. The home had a compliance history of one of more non-compliances, none of which were for the same subsection. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 10, 2020

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, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 26th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Kuorikoski

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