Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 29, 2020	2020_633577_0006	001667-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Southbridge Roseview
99 Shuniah Street THUNDER BAY ON P7A 2Z2

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

DEBBIE WARPULA (577)

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): March 2-6 and 9-10, 2020.

The following intakes were inspected during this Critical Incident System (CIS) Inspection:
- One intake related to a resident altercation and fall.

Complaint (CO) Inspection #2020_633577_0007 was conducted concurrently with this CIS Inspection.

During the course of the inspection, the inspector(s) spoke with the the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Resident Assessment Instrument (RAI) Coordinator, the Behavioural Supports Ontario Mobile Outreach Team, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, and various policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 who demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented

a) A Critical Incident System (CIS) report was received by the Director on an identified date, related to resident #002, who had a specified incident and suffered an injury. During the time of the incident, resident #002 had verbalized that a co-resident had engaged in a specific activity. The report further indicated that resident #001 was found to have been in and out of resident #002's room numerous times during that evening, before and after the incident.

A review of the home's policy, "Responsive behaviours - RC-17-01-04", revised December 2019, indicated that staff were to have developed a care plan that addressed the risk of any identified behaviours and provided goals and interventions to promote safe, quality care for every resident with an Aggressive Behaviour Scale (ABS) score of 2 or higher. They were to have ensured that the care plan included a description of the behaviour, triggers to the behaviour, preventative measures to minimize the risk of the behaviour developing or escalating, resident specific interventions to address behaviours and strategies staff were to follow if the interventions were not effective. The Dementia Observation System (DOS) was to be used to document observed behaviour over time (five to seven days), to evaluate any patterns of behaviour identified.

During a record review, Inspector #577 found 26 progress notes over a specified time

period, where resident #001 had been found in resident #002's room, engaged in specific activities.

A record review of resident #001's care plan, prior to the incident, had not contained any interventions or an identified focus related to a specified behaviour.

Inspector #577 reviewed the physician's orders for an identified date, which instructed nursing staff to document a specific type of assessment record over a specified time period.

Inspector #577 reviewed the assessment record initiated on an identified date, and found inconsistencies in the documentation. On five identified dates, there was no documentation over a specified time period.

A review of the home's investigation notes indicated RPN #100 had found resident #002 lying in a specific position in their bedroom and suffered specific injuries; they told staff that someone had engaged in a specific activity involving resident #002. Resident #001 was constantly in resident #002's room throughout the day and had been redirected numerous times but kept going back into resident #002's room.

A progress note on the day of, and prior to the incident, indicated that resident #002's Power of Attorney (POA) had expressed frustration with resident #001 entering resident 002's room constantly and engaged in a specific activity.

During an interview with RPN #101 and PSW #102, they reported that resident #001 had a tendency to engage in a specific behaviour quite frequently. They further reported that staff would re-direct them away from the room.

During an interview with RPN #100, they reported to Inspector #577 that they had found resident #002 on the floor in their room in a specific position and suffered a specific injury; the resident told them that someone had engaged in a specific activity and staff had been aware that resident #001 was known to engage in a specific activity.

During an interview, the Director of Care (DOC), together with Inspector #577, reviewed resident #001's specific assessment records. They confirmed the inconsistent documentation.

During an interview with the Assistant Director of Care (ADOC) #103, they reported to

Inspector #577 that they determined through video footage that resident #001 was in and out of resident #002's room that day; resident #002 had been found on the floor, and they had verbalized that someone had engaged in a specific activity. They confirmed that they had concluded that resident #001 had engaged in a specific activity that involved resident #002. They further confirmed that there weren't any care plan interventions for resident #001 related to their specific behaviour involving resident #002's room.

b) A record review of resident #004's progress notes, had indicated that a specific assessment record was initiated to monitor their behaviour as they had demonstrated specific behaviour towards staff and engaged in a specific activity that involved a co-resident's room.

Inspector #577 reviewed the assessment record initiated on an identified date, and found inconsistencies in the documentation. On three identified dates, there was no documentation over a specified time period.

During an interview, RPN #104, together with Inspector #577 reviewed resident #004's assessment records and they confirmed the inconsistent documentation. They reported that Personal Support Workers (PSWs) were responsible to have documented on the assessment records.

During an interview, the DOC, together with Inspector #577, reviewed resident #004's assessment records. They confirmed the inconsistent documentation.

c) During the inspection, Inspector #577 observed resident #003 to exhibit specific behaviour, that appeared spontaneous and uncontrollable. The resident was found in their wheelchair seated in a particular location after morning care each day. The behaviour was heard by Inspector #577 during the morning and afternoon over seven identified dates and could be heard while in the elevator.

Inspector #577 was approached by a family member of another resident residing in the home. They expressed frustration concerning the specific behaviour of resident #003. They verbalized mental exhaustion of residents, staff and visitors due to the specific behaviour. They reported that they had verbalized their concerns to the home's administration on three previous occasions and had been told that there was nothing more that could be done.

During observations during the morning and afternoon over seven identified dates,

Inspector #577 observed constant repetitive behaviours from resident #003. The behaviour would lessen when a staff member would engage in a specific activity with them.

During observations on an identified date, resident #003 was seated in a particular area, repetitively engaged in a specific activity. Resident #004 was in their wheelchair by the nursing station, and Inspector #577 heard them verbalize a specific word to resident #003.

During observations on an identified date, resident #003 was sitting in a particular area, repetitively engaged in an activity. Resident #005 called out twice for resident #003 to stop. Resident #005 reported to the Inspector that it was a constant activity.

During observations on an identified date, PSW #106 sat with resident in a particular area for a few minutes, and the resident screamed.

During frequent daily observations on the unit, Inspector #577 observed resident #003 grab a staff members hand to hold their hand, when they approached the resident. The resident also would hold the Inspector’s hand. The resident would settle when holding someone’s hand.

A review of the home's program, "Responsive behaviours - RC-17-01-04", revised December 2019, indicated that staff were required to complete accurate documentation in the resident's health record when behaviours were observed; the documentation were to clearly describe any identified triggers to the behaviour, how the behaviour was displayed, what interventions were tried, what interventions were unsuccessful or successful, and any negative experience or outcome for the resident or another person/resident. A resident was to be referred to a psychogeriatric resource for further assessment and care plan intervention if the resident was not responding to non-pharmacologic and /or pharmacologic interventions implemented; resident who was escalating despite interventions implemented; the admission meeting revealed information that indicated the resident’s behaviour fluctuated and was not predictable; and/or resident behaviour placed the resident or others at risk of harm.

A record review of resident #003’s care plan identified that the resident had repetitive specific behaviours and directed staff to refer to the Specialized Services recommendations for suggested interventions to consider.

A record review of the Specialized Services Consultant Assessment on a specified date, directed staff to utilize specific interventions.

A record review of the progress notes documented by PRC #107, over a four month period, indicated ten notes that requested staff to document all specific behaviours.

During a record review of progress notes over a five month period, Inspector #577 found three nursing progress notes which indicated a description of resident’s behaviour with the non-pharmacological interventions that were tried.

A review of a progress note on an identified date, by BSO PSW #108, indicated that a RPN had told them that most attempts of redirecting the resident with specific non-pharmacological interventions were ineffective; and resident appeared more calm/quiet when a staff member was engaged in a specific activity with them.

Inspector #577 reviewed the physician’s orders on an identified date, which instructed nursing staff to document a specific assessment record for three days. An order on another identified date, instructed nursing staff to continue the specific assessment record for seven more days.

Inspector #577 reviewed the assessment record initiated on an identified date, and found inconsistencies in the documentation. On ten identified dates, there was no documentation over a specified time period.

A review of Resident #003’s health care record by Inspector #577 found no involvement in the resident's care by a specific Specialized Service designated in dealing with specific behaviours.

During an interview with Inspector #577, RPN #109 advised that the home had tried five specific interventions to manage their specific behaviours, but this did not seem to work. They reported that the resident seemed to settle when someone had engaged in a specific activity with them, and it was the only intervention that seemed to work.

During an interview with Inspector #577, RPN #112 advised that resident #003 always exhibited specific behaviour and pharmacological and non pharmacological interventions had been unsuccessful.

During an interview with Inspector #577, RN #110 advised that the home had been

trialing different medication and nothing had helped. They further reported that the only intervention that seemed to work was when a staff member engaged in a specific activity with them.

During an interview with PRC #107, they advised that they had been involved in resident #003's care since an identified date, where they had given the staff strategies to assist with resident #003's specific behaviour. They reported that when the resident was distracted, the specific behaviours were less; they trialed five specific interventions and indicated that sometimes the strategies would work, but all of the strategies were trialed and were unsuccessful; they confirmed that staff haven't been consistently documenting the residents specific behaviours with non pharmacological strategies used.

In an interview with the DOC, they reported that all of the pharmalogical and non pharmalogical strategies used had been unsuccessful and nothing was working for the resident right now. They reviewed the specific assessment records and confirmed that the documentation was inconsistent. They reported that there was no funding available for specific support for the resident and there hadn't been a referral to the specific Specialized Service designated in dealing with specific behaviours.

As evidenced by observations, interviews with staff, residents, a family member, and a review of residents health care records; resident #003 was displaying ongoing specific behaviours in the home that were affecting the quality of life of other residents within the home. [s. 53. (4) (c)]

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #002.

A Critical Incident System (CIS) report was received by the Director on an identified date, related to resident #002, who had a fall and suffered an injury. The report further indicated that staff assisted them off the floor and back into their bed.

A review of the home's policy, "Falls Prevention and Management Program - RC-15-01-01", revised December 2019, indicated on the 'Post Fall Clinical Pathway', that when a resident had fallen and was found on the floor, staff could decide not to move the resident and call the ambulance or they were to move the resident using a mechanical lift, if the resident had not gotten up independently.

A review of the home's policy, "Safe Lifting with Care Program - LP-01-01-01", revised August 2017, indicated that when the resident assessment indicated that a mechanical lift was required, staff would follow the established procedure and use approved mechanical lifting equipment.

A review of resident #002's progress notes related to the specified incident, indicated that resident #002 had been found on the floor and four staff transferred them back to bed without the assistance of specific equipment.

A review of the home's investigation notes indicated RPN #100 had found resident #002 lying on the floor in their bedroom and appeared to have suffered a specific injury; and four staff lifted the resident into their bed without the assistance of specific equipment.

During an interview with RPN#100, they reported to Inspector #577 that when they had assessed resident #002 after their specified incident, the resident had signs of a specific injury and they directed staff to transfer them back to their bed without the assistance of specific equipment. They further reported that staff were supposed to use specific equipment to transfer residents off the floor.

During an interview with RPN #101, they reported to Inspector #577 that staff were required to use specific equipment to transfer a resident off the floor after a fall.

During an interview with the DOC, they reported that staff should have left the resident on the floor until the ambulance arrived or they should have used specific equipment when they transferred the resident off the floor; further, staff were not following the home's Falls policy when they lifted the resident without the assistance of specific equipment [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to make a report in writing to the Director setting out the following with respect to an incident reported under subsection (1), (3) or (3.1): Actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.

A CIS report was received by the Director on an identified date, related to resident #002, who had a specified incident and suffered an injury. During the time of the incident, resident #002 had verbalized that a co-resident had engaged in a specific activity.

Inspector #577 reviewed the CIS report and found that the report indicated that resident #002 was admitted to an acute care hospital with an identified injury and was likely awaiting a specific procedure; under the heading of outcome/current status of the individual who were involved in the occurrence. Inspector #577 found that there were no amendments made to include information regarding the resident’s aforementioned procedure, the date when the resident had returned to the home, or their status upon their return.

A review of the home's policy, "Critical Incident Reporting - RC-09-01-06", revised June 2019, indicated that the critical incident report was to be amended with new or additional information as it became available and submitted to the Ministry of Health and Long-Term Care (MOHLTC) within the established time frames.

During separate interviews with the ADOC and the DOC, they confirmed that the documentation on the CIS report had not been amended to have included information related to resident #002’s possible procedure, their return date to the home or their status upon their return. [s. 107. (4) 3. v.]

2. The licensee has failed to make a report in writing to the Director setting out the following with respect to an incident reported under subsection (1), (3) or (3.1): Analysis and follow-up action, including, the long-term actions planned to correct the situation and prevent recurrence.

A Critical Incident System (CIS) report was received by the Director on an identified date, related to resident #002, who had a specified incident and suffered an injury. During the time of the incident, resident #002 had verbalized that a co-resident had engaged in a specific activity.

Inspector #577 reviewed the CIS report for amendments related to the long-term actions planned to correct the situation and prevent a recurrence. The report indicated that the status of resident #002 would be assessed upon readmission to the home and the care plan would be updated; co-resident #001 continued to be followed by Specialized Services and reviewed at resident care rounds every two weeks for known behaviours. Inspector #577 found that there were no amendments made to include information regarding long-term actions.

A review of the home's policy, "Critical Incident Reporting - RC-09-01-06", revised June 2019, indicated that the critical incident report was to be amended with new or additional information as it became available and submitted to the Ministry of Health and Long-Term Care (MOHLTC) within the established time frames.

During separate interviews with the ADOC and DOC, together with Inspector #577, reviewed the amended CIS report. They confirmed that the documentation for long-term actions did not contain sufficient information, and should have been further amended. [s. 107. (4) 4.]

Issued on this 2nd day of June, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577)
Inspection No. / No de l'inspection :	2020_633577_0006
Log No. / No de registre :	001667-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 29, 2020
Licensee / Titulaire de permis :	CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Southbridge Roseview 99 Shuniah Street, THUNDER BAY, ON, P7A-2Z2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Joanne Lent

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

To CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 001

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 in compliance with Ontario Regulation (O. Reg.) 79/10, s.53 (4)
Specifically the licensee must:

a) Develop and implement a process to ensure that staff are completing Dementia Observation System (DOS) documentation, as per the home's policies and procedures.

b) Ensure that service providers are consulted for residents exhibiting escalating responsive behaviour, as set out in the home's policy, "Responsive behaviours - RC-17-01-04", revised December 2019.

Grounds / Motifs :

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

a) A Critical Incident System (CIS) report was received by the Director on an identified date, related to resident #002, who had a specified incident and suffered an injury. During the time of the incident, resident #002 had verbalized that a co-resident had engaged in a specific activity. The report further indicated

that resident #001 was found to have been in and out of resident #002's room numerous times during that evening, before and after the incident.

A review of the home's policy, "Responsive behaviours - RC-17-01-04", revised December 2019, indicated that staff were to have developed a care plan that addressed the risk of any identified behaviours and provided goals and interventions to promote safe, quality care for every resident with an Aggressive Behaviour Scale (ABS) score of 2 or higher. They were to have ensured that the care plan included a description of the behaviour, triggers to the behaviour, preventative measures to minimize the risk of the behaviour developing or escalating, resident specific interventions to address behaviours and strategies staff were to follow if the interventions were not effective. The Dementia Observation System (DOS) was to be used to document observed behaviour over time (five to seven days), to evaluate any patterns of behaviour identified.

During a record review, Inspector #577 found 26 progress notes over a specified time period, where resident #001 had been found in resident #002's room, engaged in specific activities.

A record review of resident #001's care plan, prior to the incident, had not contained any interventions or an identified focus related to a specified behaviour.

Inspector #577 reviewed the physician's orders for an identified date, which instructed nursing staff to document a specific type of assessment record over a specified time period.

Inspector #577 reviewed the assessment record initiated on an identified date, and found inconsistencies in the documentation. On five identified dates, there was no documentation over a specified time period.

A review of the home's investigation notes indicated RPN #100 had found resident #002 lying in a specific position in their bedroom and suffered specific injuries; they told staff that someone had engaged in a specific activity involving resident #002. Resident #001 was constantly in resident #002's room throughout the day and had been redirected numerous times but kept going back into resident #002's room.

A progress note on the day of, and prior to the incident, indicated that resident #002's Power of Attorney (POA) had expressed frustration with resident #001 entering resident 002's room constantly and engaged in a specific activity.

During an interview with RPN #101 and PSW #102, they reported that resident #001 had a tendency to engage in a specific behaviour quite frequently. They further reported that staff would re-direct them away from the room.

During an interview with RPN #100, they reported to Inspector #577 that they had found resident #002 on the floor in their room in a specific position and suffered a specific injury; the resident told them that someone had engaged in a specific activity and staff had been aware that resident #001 was known to engage in a specific activity.

During an interview, the Director of Care (DOC), together with Inspector #577, reviewed resident #001's specific assessment records. They confirmed the inconsistent documentation.

During an interview with the Assistant Director of Care (ADOC) #103, they reported to Inspector #577 that they determined through video footage that resident #001 was in and out of resident #002's room that day; resident #002 had been found on the floor, and they had verbalized that someone had engaged in a specific activity. They confirmed that they had concluded that resident #001 had engaged in a specific activity that involved resident #002. They further confirmed that there weren't any care plan interventions for resident #001 related to their specific behaviour involving resident #002's room.

b) A record review of resident #004's progress notes, had indicated that a specific assessment record was initiated to monitor their behaviour as they had demonstrated specific behaviour towards staff and engaged in a specific activity that involved a co-resident's room.

Inspector #577 reviewed the assessment record initiated on an identified date, and found inconsistencies in the documentation. On three identified dates, there was no documentation over a specified time period.

During an interview, RPN #104, together with Inspector #577 reviewed resident #004's assessment records and they confirmed the inconsistent documentation. They reported that Personal Support Workers (PSWs) were responsible to have documented on the assessment records.

During an interview, the DOC, together with Inspector #577, reviewed resident #004's assessment records. They confirmed the inconsistent documentation.

c) During the inspection, Inspector #577 observed resident #003 to exhibit specific behaviour, that appeared spontaneous and uncontrollable. The resident was found in their wheelchair seated in a particular location after morning care each day. The behaviour was heard by Inspector #577 during the morning and afternoon over seven identified dates and could be heard while in the elevator.

Inspector #577 was approached by a family member of another resident residing in the home. They expressed frustration concerning the specific behaviour of resident #003. They verbalized mental exhaustion of residents, staff and visitors due to the specific behaviour. They reported that they had verbalized their concerns to the home's administration on three previous occasions and had been told that there was nothing more that could be done.

During observations during the morning and afternoon over seven identified dates, Inspector #577 observed constant repetitive behaviours from resident #003. The behaviour would lessen when a staff member would engage in a specific activity with them.

During observations on an identified date, resident #003 was seated in a particular area, repetitively engaged in a specific activity. Resident #004 was in their wheelchair by the nursing station, and Inspector #577 heard them verbalize a specific word to resident #003.

During observations on an identified date, resident #003 was sitting in a particular area, repetitively engaged in an activity. Resident #005 called out twice for resident #003 to stop. Resident #005 reported to the Inspector that it was a constant activity.

During observations on an identified date, PSW #106 sat with resident in a

particular area for a few minutes, and the resident screamed.

During frequent daily observations on the unit, Inspector #577 observed resident #003 grab a staff members hand to hold their hand, when they approached the resident. The resident also would hold the Inspector's hand. The resident would settle when holding someone's hand.

A review of the home's program, "Responsive behaviours - RC-17-01-04", revised December 2019, indicated that staff were required to complete accurate documentation in the resident's health record when behaviours were observed; the documentation were to clearly describe any identified triggers to the behaviour, how the behaviour was displayed, what interventions were tried, what interventions were unsuccessful or successful, and any negative experience or outcome for the resident or another person/resident. A resident was to be referred to a psychogeriatric resource for further assessment and care plan intervention if the resident was not responding to non-pharmacologic and /or pharmacologic interventions implemented; resident who was escalating despite interventions implemented; the admission meeting revealed information that indicated the resident's behaviour fluctuated and was not predictable; and/or resident behaviour placed the resident or others at risk of harm.

A record review of resident #003's care plan identified that the resident had repetitive specific behaviours and directed staff to refer to the Specialized Services recommendations for suggested interventions to consider.

A record review of the Specialized Services Consultant Assessment on a specified date, directed staff to utilize specific interventions.

A record review of the progress notes documented by PRC #107, over a four month period, indicated ten notes that requested staff to document all specific behaviours.

During a record review of progress notes over a five month period, Inspector #577 found three nursing progress notes which indicated a description of resident's behaviour with the non-pharmacological interventions that were tried.

A review of a progress note on an identified date, by BSO PSW #108, indicated

that a RPN had told them that most attempts of redirecting the resident with specific non-pharmacological interventions were ineffective; and resident appeared more calm/quiet when a staff member was engaged in a specific activity with them.

Inspector #577 reviewed the physician's orders on an identified date, which instructed nursing staff to document a specific assessment record for three days. An order on another identified date, instructed nursing staff to continue the specific assessment record for seven more days.

Inspector #577 reviewed the assessment record initiated on an identified date, and found inconsistencies in the documentation. On ten identified dates, there was no documentation over a specified time period.

A review of Resident #003's health care record by Inspector #577 found no involvement in the resident's care by a specific Specialized Service designated in dealing with specific behaviours.

During an interview with Inspector #577, RPN #109 advised that the home had tried five specific interventions to manage their specific behaviours, but this did not seem to work. They reported that the resident seemed to settle when someone had engaged in a specific activity with them, and it was the only intervention that seemed to work.

During an interview with Inspector #577, RPN #112 advised that resident #003 always exhibited specific behaviour and pharmacological and non pharmacological interventions had been unsuccessful.

During an interview with Inspector #577, RN #110 advised that the home had been trialing different medication and nothing had helped. They further reported that the only intervention that seemed to work was when a staff member engaged in a specific activity with them.

During an interview with PRC #107, they advised that they had been involved in resident #003's care since an identified date, where they had given the staff strategies to assist with resident #003's specific behaviour. They reported that when the resident was distracted, the specific behaviours were less; they trialed

five specific interventions and indicated that sometimes the strategies would work, but all of the strategies were trialed and were unsuccessful; they confirmed that staff haven't been consistently documenting the residents specific behaviours with non pharmacological strategies used.

In an interview with the DOC, they reported that all of the pharmalogical and non pharmalogical strategies used had been unsuccessful and nothing was working for the resident right now. They reviewed the specific assessment records and confirmed that the documentation was inconsistent. They reported that there was no funding available for specific support for the resident and there hadn't been a referral to the specific Specialized Service designated in dealing with specific behaviours.

As evidenced by observations, interviews with staff, residents, a family member, and a review of residents health care records; resident #003 was displaying ongoing specific behaviours in the home that were affecting the quality of life of other residents within the home. [s. 53. (4) (c)]

The decision to issue a Compliance Order (CO) was based on the severity which indicated actual harm had occurred to a resident and the scope which was widespread. In addition, the home's compliance history which indicated previous unrelated non compliance. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 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 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:

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

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 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 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 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 29th day of May, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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