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
May 10, 2013	2013_196157_0013	O-000287-13	Complaint

Licensee/Titulaire de permis

MARYCREST HOME FOR THE AGED
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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

PATRICIA POWERS (157), CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 18, 19, May 2, 2013

During the course of the inspection, the inspector(s) spoke with The Chief Executive Officer, the Director of Resident Care(DORC), Unit Manager, Registered Nurse (RN), four Registered Practical Nurses (RPN), Director of Resident and Family Services, Education Coordinator, nine Personal Support Workers (PSW), one resident, family member of one resident.

During the course of the inspection, the inspector(s) reviewed the clinical health records for fifteen residents, reviewed the licensee's Risk Management Incident Reports, Critical Incidents, Behavioural Support Ontario (BSO) program, policies related to Incident Reports, Behaviour Management, Aggressive Incident Reports and Resident Abuse and Neglect - Zero Tolerance, reviewed staff education records, observed resident behaviours on Woodland Unit, observed staff:resident interactions and care and services provided to residents on Woodland Unit

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	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.) 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. (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).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

Findings/Faits saillants :

1. The licensee's responsive behaviour program - Resident Safeguards and Services, "Behaviour Management", Policy No.145-60, Revised May 9, 2005, fails to provide:
- 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.
- written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours
- resident monitoring protocols
- protocols for the referral of residents to specialized resources where required (s.53. (1)1.) [s. 53. (1)]

2. There is no evidence, as stated by the Director of Resident Care, that the program to manage responsive behaviours is evaluated annually and updated in accordance with evidence based or prevailing practices. [s. 53. (3) (b)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The clinical health record for resident #02, was reviewed for an identified period of 7 months and indicated the following:
- Five incidents of aggressive behaviour directed at other residents.
- Five incidents of aggressive behaviour directed at staff.
The plan of care for resident #02 failed to provide clear direction to staff and others who provide direct care to the resident for interventions for the management of aggressive behaviours. [s. 6. (1) (c)]

2. The clinical health record for resident #04 was reviewed for the period of 4 months and indicated that the resident demonstrated 9 incidents of aggressive behaviours towards other residents.

The written plan of care for resident #04 failed to provide clear direction to staff and others who provided direct care to the resident for interventions for the management of aggressive behaviours. [s. 6. (1) (c)]

3. The clinical health record for resident #03 was reviewed for an identified period of 5 months and indicated that the resident demonstrated 8 incidents of wandering behaviour.
The written plan of care for resident #03 fails to provide clear direction to staff and others who provide direct care to the resident for interventions for the management of behaviours of wandering into other residents rooms. [s. 6. (1) (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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The clinical health record for resident #02, was reviewed for an identified period of 7 months and indicated that on an identified date the resident demonstrated aggressive behaviour towards another resident causing injury.

There is no evidence that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #02 and other residents by identifying and implementing interventions for this wandering and aggressive behaviour. [s. 54. (b)]

2. The clinical health record for resident #04 was reviewed for the period of 4 months and indicated that the resident demonstrated 9 incidents of aggressive behaviours towards other residents.

There is no evidence that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #04 and other residents by identifying and implementing interventions for this aggressive behaviour. [s. 54. (b)]

3. The clinical health record for resident #03 was reviewed for an identified period of 5 months and indicated that the resident demonstrated 8 incidents of wandering behaviour.

There is no evidence that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #03 and other residents by identifying interventions for this behaviour of wandering into other resident rooms. [s. 54. (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. On April 23, 2013, an interview with the DORC clarified the following to be the licensee's practice for the investigation of alleged, suspected or witnessed incidents of abuse:
- an internal incident report is completed for all resident incidents in the home
- where there is an alleged, suspected or witnessed incident of abuse, a critical incident report is completed for submission to the MOHLTC, providing details of an analysis of the incident, immediate and long term actions taken and the results of the investigation
- the plan of care is amended as required

On an identified date, staff witnessed an incident between resident #01 and resident #02. An internal incident report states resident #02 wandered into resident #01's room and demonstrated aggressive behaviour resulting in physical injury to resident #01.
The licensee failed to immediately investigate a witnessed incident of physical abuse and a report with the results of the investigation were not submitted to the Director as required.[s.23.(2)] [s. 23. (1) (a)]

2. On an identified date, resident #04 was witnessed by staff entering resident #01's room. Resident #04 demonstrated aggressive behaviour towards resident #01, resulting in physical injury to both residents.
The licensee failed to immediately investigate a witnessed incident of physical abuse and a report with the results of the investigation were not submitted to the Director as required.[s.23.(2)] [s. 23. (1) (a)]

3. On an identified date, staff witnessed an incident between resident #04 and resident #06. Resident #04 demonstrated aggressive behaviour toward resident #06 resulting in physical injury.
The licensee failed to immediately investigate a witnessed incident of physical abuse and a report with the results of the investigation were not submitted to the Director as required.[s.23.(2)] [s. 23. (1) (a)]

4. On an identified date resident #25 reported being struck by resident #30, resulting in physical injury. The licensee failed to immediately investigate a witnessed incident of physical abuse and a report with the results of the investigation were not submitted to the Director as required. [s.23.(1)(a)] [s. 23. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect the identified residents in the home from abuse by anyone as evidenced by the following;
- There is no clear direction in the written plans of care to staff and others who provide direct care to residents related to the management of responsive behaviours (as identified in WN#2)
- The Director has not been immediately notified where there has been alleged, suspected or witnessed incidents of abuse (as identified in WN#7)
- No immediate investigation of incidents of alleged, suspected or witnessed abuse has been completed (as identified in WN#4)
- Results of the investigation of incidents of alleged, suspected or witnessed abuse have not been forwarded to the Director as required (as identified in WN#4)
- Police have not been notified of alleged, suspected or witnessed incidents of abuse that the licensee suspects may constitute a criminal offence (as identified in WN#6)
- The licensee's current program for the management of responsive behaviours fails to provide the required direction to meet the needs of resident's with responsive behaviours in accordance with the requirements of the legislation.(as identified in WN#1) [s. 19. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee did not immediately notify the police of the following incidents of physical abuse resulting in harm to a resident:

- On an identified date, staff witnessed an incident between resident #01 and resident #02. An internal incident report states resident #02 wandered into resident #01's room and demonstrated aggressive behaviour resulting in physical injury to resident #01. Police were not notified.

- On an identified date, resident #04 was witnessed by staff entering resident #01's room. Resident #04 demonstrated aggressive behaviour towards resident #01, resulting in physical injury to both residents. Police were not notified.

- On an identified date, staff witnessed an incident between resident #04 and resident #06. Resident #04 demonstrated aggressive behaviour toward resident #06 resulting in physical injury. Police were not notified.

- On an identified date resident #25 reported being struck by resident #30, resulting in physical injury. Police were not notified. [s. 98.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. On an identified date, staff witnessed an incident between resident #01 and resident #02. An internal incident report states resident #02 wandered into resident #01's room and demonstrated aggressive behaviour resulting in physical injury to resident #01.
The licensee did not report to the Director the witnessed physical abuse of a resident that resulted in harm. [s. 24. (1)]

2. On an identified date, resident #04 was witnessed by staff entering resident #01's room. Resident #04 demonstrated aggressive behaviour towards resident #01, resulting in physical injury to both residents.
The licensee did not report to the Director the witnessed physical abuse of a resident that resulted in harm. [s. 24. (1)]

3. On an identified date, staff witnessed an incident between resident #04 and resident #06. Resident #04 demonstrated aggressive behaviour toward resident #06 resulting in physical injury.
The licensee did not report to the Director the witnessed physical abuse of a resident that resulted in harm. [s. 24. (1)]

4. On an identified date resident #25 reported being struck by resident #30, resulting in physical injury.
The licensee did not report to the Director the alleged physical abuse of a resident that resulted in harm. [s. 24. (1)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: 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. LTCHA, O.Reg. 79/10 s.53.(1)3. requires that the licensee ensure that internal reporting protocols are developed to meet the needs of residents with responsive behaviours. The Licensee's policy "Aggressive Incident Report" Policy No.8-07 reviewed September 2011 directs the following:
"Purpose: To ensure accurate reporting of aggressive incidents demonstrated by a resident; To monitor and recognize patterns of behaviours and triggers that can initiate aggressive reactions in residents with dementia"
-initiate an internal incident report under risk management in Point Click Care (PCC). The DORC and Unit Manager state that it is the home's practice to complete an internal incident report for each resident involved in an incident.
-Inform family or Substitute Decision Maker (SDM). The DORC and Unit Manager stated that it is the home's practice to contact the SDM for each resident involved in an incident.
The licensee failed to comply with the home's above noted policy as evidenced by the following:

A review of the clinical health record for resident #25 for an identified period of 7 months indicated two incidents of aggression towards other residents. The licensee failed to complete incident reports and notify the SDM for each resident involved, as directed in the policy.

A review of the clinical health record for resident #01 indicated staff witnessed an incident where Resident #04 demonstrated aggressive behaviour towards resident #01 resulting in no physical injury. The licensee failed to complete incident reports and notify the SDM for each resident involved, as directed in the policy.

Required action is identified under compliance order #005 and the following VPC. [s. 8. (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 to ensure that the licensee's policy for "Aggressive Incident Report" is complied with by the completion an internal incident report and notification of the SDM for each resident involved in an incident of aggressive behaviour, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. There is no evidence that the licensee's policy "Abuse and Neglect (Resident) - Zero Tolerance", Resident Safeguards and Services, Policy No. 14-18, effective April 2011, has been evaluated once in every calendar year to determine the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents and to determine what changes and improvements are required to prevent further occurrences. The DORC stated that this program evaluation has not been completed. [s. 99. (b)]

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

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Issued on this 10th day of May, 2013

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

Pat Rowe #157

Chantal Lafrenière #194

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PATRICIA POWERS (157), CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2013_196157_0013
Log No. / Registre no:	O-000287-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 10, 2013
Licensee / Titulaire de permis :	MARYCREST HOME FOR THE AGED 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
LTC Home / Foyer de SLD :	ST JOSEPH'S AT FLEMING 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ALAN CAUELL ~~GARY SIMS~~

To MARYCREST HOME FOR THE AGED, 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)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required.

O. Reg. 79/10, s. 53 (1).

Order / Ordre :

The licensee shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

- written approaches to care including screening protocols, assessments, reassessments and identification of behavioural triggers that may result in responsive behaviours
- written strategies including techniques and interventions, to prevent, minimize or respond to responsive behaviours
- resident monitoring protocols
- protocols for referral of residents to specialized resources when required
- protocols to ensure that staff education is provided related to the responsive behaviour program and procedures
- process to monitor and evaluate the implementation of the responsive behaviour program

Grounds / Motifs :

1. 1. The licensee's responsive behaviour program - Resident Safeguards and Services, "Behaviour Management", Policy No.145-60, Revised May 9, 2005, fails to provide:
- 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.
- written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours
- resident monitoring protocols
- protocols for the referral of residents to specialized resources where required [s. 53. (1)]

2. There is no evidence, as stated by the Director of Resident Care, that the program to manage responsive behaviours is evaluated annually and updated in accordance with evidence based or prevailing practices. (157)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall review the plans of care for all residents currently identified with responsive behaviours to ensure that the plans of care for those residents provide clear direction to staff and others in the management of these responsive behaviours.
The licensee shall develop a monitoring process to ensure that the plans of care for all residents identified with responsive behaviours continue to provide clear direction to staff and others in the management of these responsive behaviours.

Grounds / Motifs :

1. The clinical health record for resident #02, was reviewed for an identified period of 7 months and indicated the following:
- Five incidents of aggressive behaviour directed at other residents.
- Five incidents of aggressive behaviour directed at staff.
The plan of care for resident #02 failed to provide clear direction to staff and others who provide direct care to the resident for interventions for the management of aggressive behaviours. [s. 6. (1) (c)] (157)

2. The clinical health record for resident #03 was reviewed for an identified period of 5 months and indicated that the resident demonstrated 8 incidents of wandering behaviour.
The written plan of care for resident #03 fails to provide clear direction to staff and others who provide direct care to the resident for interventions for the management of behaviours of wandering into other residents rooms. [s. 6. (1) (c)] (157)

3. The clinical health record for resident #04 was reviewed for the period of 4 months and indicated that the resident demonstrated 9 incidents of aggressive behaviours towards other residents.
The written plan of care for resident #04 failed to provide clear direction to staff and others who provided direct care to the resident for interventions for the management of aggressive behaviours. [s. 6. (1) (c)]

(157)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 17, 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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the risk of altercations and potentially harmful interactions between residents is minimized by:
(a) Development and implementation of a process to identify residents with responsive behaviours which result in a risk of altercations and potentially harmful interactions with other residents
(b) Development and implementation of interventions to respond to the identified risks
(c) Ensuring that the process provides for the ongoing reassessment of the effectiveness of interventions
(d) Establishment of a communications system to ensure that all staff are aware of the identified risks and interventions
(e) Provision of education to staff related to the identification and management of behaviours that result in the risk of altercations and the risk of potentially harmful interaction between residents

Grounds / Motifs :

1. The clinical health record for resident #04 was reviewed for the period of 4 months and indicated that the resident demonstrated 9 incidents of aggressive behaviours towards other residents.

There is no evidence that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #04 and other residents by identifying and implementing interventions for this aggressive behaviour. [s. 54. (b)]

(157)

2. The clinical health record for resident #03 was reviewed for an identified period of 5 months and indicated that the resident demonstrated 8 incidents of wandering behaviour.

There is no evidence that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #03 and other residents by identifying interventions for this behaviour of wandering into other resident rooms. [s. 54. (b)] (157)

3. The clinical health record for resident #02, was reviewed for an identified period of 7 months and indicated that on an identified date the resident demonstrated aggressive behaviour towards another resident causing injury.

There is no evidence that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #02 and other residents by identifying and implementing interventions for this wandering and aggressive behaviour. [s. 54. (b)]
(157)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2013

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone is immediately investigated and that the results of such investigation are reported to the Director.

Grounds / Motifs :

1. On April 23, 2013, an interview with the DORC clarified the following to be the licensee's practice for the investigation of alleged, suspected or witnessed incidents of abuse:
- an internal incident report is completed for all resident incidents in the home
- where there is an alleged, suspected or witnessed incident of abuse, a critical incident report is completed for submission to the MOHLTC, providing details of an analysis of the incident, immediate and long term actions taken and the results of the investigation
- the plan of care is amended as required

1. On an identified date, staff witnessed an incident between resident #01 and resident #02. An internal incident report states resident #02 wandered into resident #01's room and demonstrated aggressive behaviour resulting in

physical injury to resident #01.
The licensee failed to immediately investigate a witnessed incident of physical abuse and a report with the results of the investigation were not submitted to the Director as required.[s.23.(2)] [s. 23. (1) (a)]

2. On an identified date, resident #04 was witnessed by staff entering resident #01's room. Resident #04 demonstrated aggressive behaviour towards resident #01, resulting in physical injury to both residents.
The licensee failed to immediately investigate a witnessed incident of physical abuse and a report with the results of the investigation were not submitted to the Director as required.[s.23.(2)] [s. 23. (1) (a)]

3. On an identified date, staff witnessed an incident between resident #04 and resident #06. Resident #04 demonstrated aggressive behaviour toward resident #06 resulting in physical injury.
The licensee failed to immediately investigate a witnessed incident of physical abuse and a report with the results of the investigation were not submitted to the Director as required.[s.23.(2)] [s. 23. (1) (a)]

4. On an identified date resident #25 reported being struck by resident #30, resulting in physical injury. The licensee failed to immediately investigate a witnessed incident of physical abuse and a report with the results of the investigation were not submitted to the Director as required. [s.23.(1)(a)] [s. 23. (2)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 13, 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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:
(a) A process to ensure that residents who demonstrate responsive behaviours shall have a written plan of care that includes at a minimum:
- clear direction to staff and others who provide direct care to the resident
- is reassessed when the resident's care needs change and revised when interventions are ineffective
- identification of behavioural triggers
- documented strategies to respond to the resident's responsive behaviours
- documentation of the resident's responses to interventions
- actions to be taken to minimize the risk of altercations and potentially harmful interactions between and among residents
(b) The development of a monitoring process to ensure that:
- the Director is immediately notified if there are reasonable grounds to suspect abuse of a resident that resulted in harm or risk of harm to a resident and unlawful conduct that resulted in harm or risk of harm to a resident.
- that a written report is submitted to the Director with respect to the alleged, suspected or witnessed incident of abuse or a resident by anyone to include:
 - a description of the incident and the individuals involved
 - action taken in response to the incident
 - analysis and follow up action
 - the name and title of the person making the report
- that the Director is informed of the results of every investigation undertaken in response to an alleged, suspected or witnessed incident of abuse
- that the appropriate police force is notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may

constitute a criminal offence.
(c) Ensure that staff education is provided which includes legislated reporting requirements of all incidents of alleged, suspected or witnessed incidents of abuse of a resident.
(d) A process to monitor, evaluate and ensure compliance with the Responsive Behaviour Program which has been developed as directed in CO#1.

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

The plan is to be submitted to Patricia Powers by May 31, 2013 via email at patricia.powers@ontario.ca.

Grounds / Motifs :

1. The licensee failed to protect the identified residents in the home from abuse by anyone as evidenced by the following;
- There is no clear direction in the written plans of care to staff and others who provide direct care to residents related to the management of responsive behaviours (as identified in WN#2)
- The Director has not been immediately notified where there has been alleged, suspected or witnessed incidents of abuse (as identified in WN#7)
- No immediate investigation of incidents of alleged, suspected or witnessed abuse has been completed (as identified in WN#4)
- Results of the investigation of incidents of alleged, suspected or witnessed abuse have not been forwarded to the Director as required (as identified in WN#4)
- Police have not been notified of alleged, suspected or witnessed incidents of abuse that the licensee suspects may constitute a criminal offence (as identified in WN#6)
- The licensee's current program for the management of responsive behaviours fails to provide the required direction to meet the needs of resident's with responsive behaviours in accordance with the requirements of the legislation.(as identified in WN#1) (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Order / Ordre :

The licensee shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

Grounds / Motifs :

1. 1. The licensee did not immediately notify the police of the following incidents of physical abuse resulting in harm to a resident:

- On an identified date, staff witnessed an incident between resident #01 and resident #02. An internal incident report states resident #02 wandered into resident #01's room and demonstrated aggressive behaviour resulting in physical injury to resident #01. Police were not notified.

- On an identified date, resident #04 was witnessed by staff entering resident #01's room. Resident #04 demonstrated aggressive behaviour towards resident #01, resulting in physical injury to both residents. Police were not notified.

- On an identified date, staff witnessed an incident between resident #04 and resident #06. Resident #04 demonstrated aggressive behaviour toward resident #06 resulting in physical injury. Police were not notified.

- On an identified date resident #25 reported being struck by resident #30, resulting in physical injury. Police were not notified. [s. 98.] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 13, 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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

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

Order / Ordre :

The licensee shall ensure that a person who has reasonable grounds to suspect the abuse of a resident by anyone that resulted in harm or risk of harm to a resident, immediately reports the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. On an identified date, staff witnessed an incident between resident #01 and resident #02. An internal incident report states resident #02 wandered into resident #01's room and demonstrated aggressive behaviour resulting in physical injury to resident #01.
The licensee did not report to the Director the witnessed physical abuse of a resident that resulted in harm. [s. 24. (1)]
(194)

2. On an identified date, resident #04 was witnessed by staff entering resident #01's room. Resident #04 demonstrated aggressive behaviour towards resident #01, resulting in physical injury to both residents.
The licensee did not report to the Director the witnessed physical abuse of a resident that resulted in harm. [s. 24. (1)]
(194)

3. On an identified date resident #25 reported being struck by resident #30, resulting in physical injury.
The licensee did not report to the Director the alleged physical abuse of a resident that resulted in harm. [s. 24. (1)]
(194)

4. On an identified date, staff witnessed an incident between resident #04 and resident #06. Resident #04 demonstrated aggressive behaviour toward resident #06 resulting in physical injury.
The licensee did not report to the Director the witnessed physical abuse of a resident that resulted in harm. [s. 24. (1)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 15, 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.

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

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 10th day of May, 2013

Signature of Inspector / Signature de l'inspecteur : Pat Powers #157, Chantal Lafreniere #194

Name of Inspector / Nom de l'inspecteur : PATRICIA POWERS / CHANTAL LAFRENIERE

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