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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 9, 2014	2014_283544_0026	S- 000292-13, 000357-14	Follow up

Licensee/Titulaire de permis

CORPORATION OF THE TOWN OF KIRKLAND LAKE
3 KIRKLAND STREET WEST POSTAL BAG 1757 KIRKLAND LAKE ON P2N 3P4

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

TECK PIONEER RESIDENCE
145A GOVERNMENT ROAD EAST POSTAL BAG SERVICE 3800 KIRKLAND LAKE ON P2N 3P4

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

FRANCA MCMILLAN (544)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 4, 5, 2014 related to:

Log # S- 000357-14
Log # S- 000292-13

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Assistant Director of Care, Registered Staff, Personal Support Workers (PSWs), Residents and Families.

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

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. (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. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

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).

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. A previous compliance order related to O Reg. 79/10, r. 53(1), was issued in Inspection # 2013_138151 on June 3, 2013, with a compliance date of July 31, 2013.

Inspector # 544 reviewed a Critical Incident Report submitted to the Director by the home.
It is alleged that Resident # 001 was pushed by Resident # 002. Resident # 001 sustained injuries that resulted in their death.

Inspector identified that in the first submission of the Critical Incident Report and the amended Critical Incident Report, it is written, Resident # 002 "remains on q15 minute checks and will continue to be monitored for any behaviours."

Inspector # 544 could not find any documentation of the 15 minute checks in Point of Care(POC), Dementia Observation System (DOS) or Resident # 002's progress notes.
Staff # 100, 101, 102 and Staff #103 stated that these were the areas where documentation was to be found for the monitoring of Resident # 002.
Staff # 100, 101, 102 and Staff # 103 confirmed that there were no q 15 minute checks documented in POC, DOS or the progress notes for Resident # 002.

Inspector # 544 identified that Resident # 002 had two (2) RAI/MDS assessments completed and noted the assessments to be exactly the same. One was completed before the incident and one after the incident.
The RAI/MDS assessment identified that Resident # 002's Cognitive Skills for decision-making were moderately impaired.

The licensee has failed to ensure that resident monitoring and internal reporting protocols are developed to meet the needs of residents with responsive behaviours. [s. 53. (1) 3.]

2. Inspector # 544 reviewed a Critical Incident Report submitted to the Director.
It is alleged that Resident # 001 was pushed by Resident # 002. Resident # 001 sustained injuries that resulted in their death.

Inspector identified that in the first submission of the Critical Incident Report and the amended Critical Incident Report Resident # 002 "remains on q15 minute checks and will continue to be monitored for any behaviours".
Inspector # 544 could not find any documentation of the 15 minute checks in Point of Care(POC), Dementia Observation System (DOS) or Resident # 002's progress notes.
Staff # 100, 101, 102 and Staff #103 stated that this was where the documentation was to be found for the monitoring of Resident # 002.
Staff # 100, 101, 102 and Staff # 103 confirmed that there were no q 15 minute checks

documented in POC, DOS or the progress notes for Resident # 002.

Resident # 002's plan of care did not identify the need to check Resident # 002 q 15 minutes. The only change to the plan of care was written, " If Resident # 002 is yelling for staff to remove other Residents, staff need to redirect Resident # 002 to their room so they can spend time alone. If they are resistant to leaving the area, the other Residents must be moved for their safety, Notify Registered Staff."

The home sent a referral for assessment on the attending physician's behalf, to a physician with the Canadian Mental Health Association in 2013, regarding Resident # 002's Responsive Behaviours.
Inspector could find no documentation regarding the status of this referral. There was no documentation in Resident # 002's health care record of this assessment being completed.
It was confirmed by Staff # 100 that Resident # 002 had not yet been assessed by the physician from the Canadian Mental Health Association, now thirteen (13) months later after the incident.

The home sent a referral to Behavioural Support Ontario (BSO) and it was re-faxed one (1) month after the incident, so that an assessment could be completed for Resident # 002. There was no documentation on Resident # 002's health care record to confirm that this referral or assessment was completed. This was confirmed by Staff # 100.
The Administrator told Inspector # 544 that they thought BSO had completed the assessment for Resident # 002
Inspector # 544 requested, from the Administrator, the assessment report from BSO as it was not in Resident # 002's health care record.
The Administrator faxed to, the Sudbury Service Area Office, a report from BSO. The report identified the initial date that BSO assessed Resident # 002 was six (6) weeks after the incident. There were a number of recommendations in this report however, they did not become part of Resident # 002's plan of care. The report was dated two and a half (2 1/2) after the incident and the report was sent to the home several days after the report was completed.

Inspector # 544 reviewed the Teck Pioneer Residence Nursing Policy: Section: Risk Management, Subject: Responsive Behaviours and it is written,
" The home is committed to ensuring the needs of residents with Responsive Behaviours are met."
The screening tools to be used are:

ABC Responsive Behaviours documentation form
Cognitive Performance Scale
Montreal Cognitive Assessment (MoCA)
Folstein Mini Mental State Exam

Inspector reviewed Resident # 001's health care record and could not find a Montreal Cognitive Assessment (MoCA) or a Folstein mini mental exam completed for Resident # 002.

Inspector # 544 reviewed "The ABC Responsive Behaviours documentation form" for Resident # 002 and found it was incomplete and did not address the q15 minute checks that were to be completed for Resident # 002.

The policy, Teck Pioneer Residence Nursing Policy: Section: Risk Management, Subject: Responsive Behaviours written July 25, 2013, also addressed referral protocols for Residents with responsive behaviours.

A referral was sent to a physician with the Canadian Mental Health Association to assess Resident # 002 in 2013. There was no documentation on Resident # 002's health care record or plan of care to identify that Resident # 002 was assessed by a physician from The Canadian Mental Health Association. A referral was re-faxed to Behavioural Support Ontario (BSO), one (1) month, after the incident occurred. There was no documentation on Resident # 002's health care record or plan of care to identify that Resident # 002 was assessed by BSO.
There was no documentation on Resident # 002's health care record to identify that Resident # 002 was assessed by a Geriatrician, a Geriatric Psychiatrist or a Psychogeriatrics Resource Consultant to assist in providing support and recommendations in dealing with Resident # 002's Responsive Behaviours as identified in their policy above.

Inspector # 544 reviewed Resident # 002's progress notes which identified that Resident # 002's Responsive Behaviours were present on their admission and were escalating to the present time.

The licensee has failed to ensure that the home's programs and services are integrated into the care that is provided to residents with responsive behaviours, is based on the assessed needs of residents with responsive behaviours and co-ordinated and implemented on an interdisciplinary basis. [s. 53. (2) (a),s. 53. (2) (b),s. 53. (2) (c)]

3. The home instituted their Responsive Behaviours Program in July 2013. Inspector # 544 could not find any documentation that the Responsive Behaviours Program was evaluated in the last year.

The home's policy regarding Responsive Behaviours stated under Program Evaluation: "Annually, the Responsive Behaviour policy including screening protocols, assessments and re-assessment tools, will be evaluated by the Best Practice committee."
Staff # 100, 101 and Staff # 102 confirmed that this has not been done.

The licensee has failed to ensure that the responsive behaviour program has been evaluated annually and updated in accordance with evidence-based practices or prevailing practices. [s. 53. (3) (b)]

4. A referral for assessment was sent by the home on behalf of the attending physician with the Canadian Mental Health Association in 2013, regarding Resident # 002's Responsive Behaviours.
Inspector could find no documentation in Resident # 002's health care record regarding the status of this referral and/or reply from Canadian Mental Health Association's physician.
Staff # 100 confirmed that the Mental Health Association physician had not yet assessed Resident # 002. A follow up by the home regarding the status of this referral was not conducted now thirteen (13) months after the referral was sent and after the incident.

A referral for assessment regarding Resident # 002's escalating responsive behaviours was sent to Behavioural Support Ontario (BSO) and it was re-faxed one (1) month after the incident. There was no documentation on Resident # 002's health care record to identify that this referral was completed.
The Administrator told Inspector that she thought the BSO assessment was completed.
Inspector # 544 requested from the Administrator, the assessment report from BSO, as it was not in Resident # 002's health care record.
The Administrator faxed to, the Sudbury Service Area Office, a report from BSO with a completion date of two and half (2 1/2) months after the incident. The report identified the initial date that BSO assessed Resident # 002 was six (6) weeks after the incident.
There were a number of recommendations in this report however, they did not become part of Resident # 002's plan of care as the report was sent to the home two and half (2 1/2) months later.

A Critical Incident report submitted by the home to the Director identified that Resident # 002 was being monitored q 15 minutes after this incident. On the amended Critical Incident report, it is written that Resident # 002 continued to be monitored q15 minutes. Staff # 100, 101, 102 and Staff # 103 stated to Inspector that this documentation should be in DOS, (Dementia Observation System) or POC (Point of Care for the Personal Support Workers) documentation.
Inspector # 544 could not find any documentation of the 15 minute checks at any time in Point of Care (POC), Dementia Observation System (DOS) or Resident # 002's progress notes.
Staff # 100, 101, 102 and Staff # 103 confirmed that there were no q 15 minute checks documented in POC, DOS or the progress notes for Resident # 002.

The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours. [s. 53. (4) (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. 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. Inspector # 544 reviewed a Critical Incident Report submitted to the Director.

It is alleged that Resident # 001 was pushed by Resident # 002. Resident # 001 sustained injuries that resulted in their death.

Inspector identified that in the first submission of the Critical Incident Report and the amended Critical Incident Report, it is written, Resident # 002 "remains on q15 minute checks and will continue to be monitored for any behaviours."

Inspector # 544 could not find any documentation of the 15 minute checks at any time in Point of Care (POC), Dementia Observation System (DOS) or progress notes.
Staff # 100, 101, 102 and Staff #103 stated that this is where the documentation would be found for the monitoring of Resident # 002.
Staff # 100, 101, 102 and Staff # 103 confirmed that there were no q 15 minute checks documented in POC, DOS or the progress notes for Resident # 002.
There was no clear direction to staff in the plan of care in regards to monitoring Resident # 002, where to document the behaviours and how often to monitor Resident # 002. After the incident occurred, the care plan was not revised. The care plan did not include the monitoring regime for Resident # 002.

The only change to Resident # 002's plan of care was "to give the medications as ordered by the physician to assist with Resident # 002's responsive behaviours, staff will monitor for responsive behaviours and notify Registered Staff immediately if Resident # 002's behaviour is escalating." "If Resident # 002 is yelling, staff are to remove other Residents and redirect Resident # 002 to their room so they can spend time alone. If Resident # 002 is resistant to leaving the area, other Residents must be removed for their safety." There were no other directions in the plan of care regarding the management of Resident # 002's behaviours.

Inspector # 544 reviewed Resident # 002's progress notes and they identified that Resident # 002's Responsive Behaviours were escalating and that they were exhibited since Resident # 002's admission.

Inspector # 544 reviewed the Teck Pioneer Residence Nursing Policy in Section: Risk Management, Subject: Responsive Behaviours, written July 25, 2013, identified that, " The home is committed to ensuring the needs of residents with Responsive Behaviours are met."
The screening tools to be used are:
ABC Responsive Behaviours documentation form
Cognitive Performance Scale
Montreal Cognitive Assessment (MoCA)
Folstein Mini Mental State Exam
Inspector reviewed Resident # 002's health care record and could not find a Montreal Cognitive Assessment (MoCA) or a Folstein mini mental exam completed for Resident # 002.
The ABC Responsive Behaviours documentation form was incomplete. The charting on the ABC Recording: Challenging Behaviours was incomplete.

This was confirmed by Staff # 102 and Staff # 103.

The Responsive Behaviours Policy also addressed referral protocols for Residents who exhibit Responsive Behaviours. As of September 5, 2014, there was no documentation on Resident # 002's health care record to confirm that Resident # 002 had been assessed by a Psychogeriatrics Resource Consultant, Behavioural Support Ontario (BSO), Community Outreach Program, a Geriatrician or a Geriatric Psychiatrist, as identified in the home's policy, to assist in providing support and recommendations in dealing with Resident # 002's Responsive Behaviours.

A referral was sent by the home on behalf of the attending physician to a physician from the Canadian Mental Health Association in 2013 regarding Resident # 002's Responsive Behaviours. Inspector could find no documentation in Resident # 002's health care record regarding the status of this referral and/or reply from Canadian Mental Health Association's physician.
It was confirmed by Staff # 100 that Resident # 002 had not as yet been assessed by The Canadian Mental Health Association's physician. A follow up by the home regarding the status of this referral was not conducted now thirteen (13) months after the incident.

The home faxed a referral to Behavioural Supports Ontario (BSO) and it was re-faxed one (1) month after the incident. There was no documentation on Resident # 002's health care record that this referral was completed.
The Administrator thought that this assessment had been completed by BSO.
Inspector # 544 requested, from the Administrator, the assessment report from BSO as it was not in Resident # 002's health care record.
The Administrator faxed to, Sudbury Service Area Office, a report from BSO. The report identified the initial date that BSO assessed Resident # 002 six (6) weeks after the incident. There were a number of recommendations in this report however, they did not become part of Resident # 002's plan of care as the report was sent to the home two and half (2 1/2) months after the incident.

Under Education in the Responsive Behaviours Program, it is written:
1. " New staff, registered staff and all PSWs will receive education re: management of Responsive Behaviours during orientation
2. Staff education sessions regarding Responsive Behaviour management will be provided annually and periodically as needed to assist all employees in understanding residents with cognitive impairment and responding to disruptive behaviour
3. Front line staff will be encouraged to attend GPA training

4. All staff, contractors and volunteers providing direct care must be orientated prior to assuming their job responsibilities and retraining annually in caring for persons with responsive behaviours and behaviour management."

Inspector # 544 identified that only 75/84 direct care staff were trained in Responsive Behaviours Management in 2013.
Even though the Responsive Behaviours Program identified annual education for all staff, only 75/95 of all staff were provided with training in 2013.

Resident # 002 had a history of responsive behaviours which were documented to be escalating according to Resident # 002's progress notes. A referral for assessment to a physician with the Canadian Mental Health Association was not completed. A referral and initial assessment was completed by however, the recommendations in the report were not part of Resident # 002's plan of care as the report was sent to the home two and half (2 1/2) months after the incident.
The amended CI identified q 15 minute checks however, this intervention was not identified in Resident # 002's care plan as per the home's policy.

Even though the Responsive Behaviours Program identified annual education for all staff, only 75/95 of all staff were provided with training in 2013.

Thus, the licensee failed to protect Resident # 001 by Resident # 002 by ensuring that Residents exhibiting responsive behaviours are assessed, referrals made and their plan of care is updated to reflect strategies to manage responsive behaviours in order that Residents are protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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. Inspector # 544 reviewed a Critical Incident Report submitted to the Director by the home.
It is alleged that Resident # 001 was pushed by Resident # 002. Resident # 001 sustained injuries that resulted in their death.

Inspector identified that in the first submission of the Critical Incident Report and the amended Critical Incident Report, it is written, Resident # 002 "remains on q15 minute checks and will continued to be monitored for any behaviours."
Inspector # 544 could not find any documentation of these 15 minute checks in Point of Care (POC), Dementia Observation System (DOS) or progress notes.
Staff # 100, 101, 102 and Staff #103 stated that this was where the documentation would be found for the monitoring of Resident # 002.
Staff # 100, 101, 102 and Staff # 103 confirmed that there were no q 15 minute checks documented in POC, DOS or the progress notes for Resident # 002.
The only change to Resident # 002's plan of care was, "to give the medications as ordered by the physician to assist with Resident # 002's responsive behaviours, staff will monitor for responsive behaviours and notify Registered Staff immediately if Resident # 002's behaviour is escalating." "If Resident # 002 is yelling, staff are to remove other Residents and redirect Resident # 002 to their room so they can spend time alone. If Resident # 002 is resistant to leaving the area, other Residents must be removed for their safety." There were no other directions in the plan of care regarding the management of Resident # 002's behaviours.

Inspector # 544 reviewed Resident # 002's progress notes and they identify that Resident # 002's Responsive Behaviours were escalating and were exhibited since Resident # 002's admission.

The licensee failed to ensure that the plan of care for Resident # 002 set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 plan of care for Resident # 002, specifically regarding the management of Responsive Behaviours, sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

s. 221. (3) The licensee shall ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours. O. Reg. 79/10, s. 221 (3).

Findings/Faits saillants :

1. Inspector # 544 reviewed a Critical Incident Report submitted to the Director by the home.

It is alleged that Resident # 001 was pushed by Resident # 002. Resident # 001 sustained injuries that resulted in their death.

Inspector # 544 reviewed the home's policy regarding Responsive Behaviours, Nursing, Section: Risk Management Subject: Responsive Behaviours and under Education, identified that:
1. " New staff, registered staff and all PSWs will receive education re: management of Responsive Behaviours during orientation.
2. Staff education sessions regarding Responsive Behaviour management will be provided annually and periodically as needed to assist all employees in understanding residents with cognitive impairment and responding to disruptive behaviour
3. Front line staff will be encouraged to attend GPA training
4. All staff, contractors and volunteers providing direct care must be orientated prior to assuming their job responsibilities and retraining annually in caring for persons with responsive behaviours and behaviour management."

Inspector # 544 identified that only 75/95 of all staff received the annual required training in Responsive Behaviours in 2013.
Only 25/84 direct care staff had training in Gentle Persuasive Approach (GPA).
This was confirmed by Staff # 100, 101 and Staff # 102.

The licensee has failed to ensure that all staff who provide direct care to residents received the required annual training in Responsive Behaviours Management. [s. 221. (2),s. 221. (2) 1.]

2. The home's policy for Responsive Behaviours, under Education, identified that:
1. " New staff, registered staff and all PSWs will receive education re: management of Responsive Behaviours during orientation.
2. Staff education sessions regarding Responsive Behaviour management will be provided annually and periodically as needed to assist all employees in understanding residents with cognitive impairment and responding to disruptive behaviour
3. Front line staff will be encouraged to attend GPA training
4. All staff, contractors and volunteers providing direct care must be orientated prior to assuming their job responsibilities and retraining annually in caring for persons with responsive behaviours and behaviour management."

Inspector # 544 identified that 25/84 direct care staff had training in Gentle Persuasive Approach (GPA).

Included in this same policy, it was further written, "ensure P.I.E.C.E.S. trained staff are part of the interdisciplinary team."
Inspector # 544 could not find any documentation or staff records that verified that any direct care staff member received P.I.E.C.E.S. training or had already been trained in the P.I.E.C.E.S. program.

The licensee has failed to ensure that all staff who provide direct care to residents receive training in techniques and approaches related to Responsive Behaviours. [s. 221. (3)]

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 all staff who provide direct care to residents receives the required annual training in Responsive Behaviours Management and training in techniques and approaches related to Responsive Behaviours, to be implemented voluntarily.

Issued on this 10th day of December, 2014

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

Original report signed by the inspector.

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	FRANCA MCMILLAN (544)
Inspection No. / No de l'inspection :	2014_283544_0026
Log No. / Registre no:	S- 000292-13, 000357-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 9, 2014
Licensee / Titulaire de permis :	CORPORATION OF THE TOWN OF KIRKLAND LAKE 3 KIRKLAND STREET WEST, POSTAL BAG 1757, KIRKLAND LAKE, ON, P2N-3P4
LTC Home / Foyer de SLD :	TECK PIONEER RESIDENCE 145A GOVERNMENT ROAD EAST, POSTAL BAG SERVICE 3800, KIRKLAND LAKE, ON, P2N-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Theriault

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To CORPORATION OF THE TOWN OF KIRKLAND LAKE, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Linked to Existing Order / Lien vers ordre existant: 2013_138151_0021, CO #001;

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: 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).

Grounds / Motifs :

1. A previous compliance order related to O Reg. 79/10, r. 53. (1), was issued in Inspection # 2013_138151_0021 with a compliance date.

Inspector # 544 reviewed a Critical Incident Report submitted to the Director by the home.

It is alleged that Resident # 001 was pushed by Resident # 002. Resident # 001 sustained injuries that resulted in their death.

Inspector identified that in the first submission of the Critical Incident Report and the amended Critical Incident report, it is written, Resident # 002 "remains on q15 minute checks and will continued to be monitored for any behaviours."

Inspector # 544 could not find any documentation on Resident # 002's health care record of the 15 minute checks at any time in Point of Care (POC), Dementia Observation System (DOS) or progress notes.
Staff # 100, 101, 102 and Staff #103 stated that this was where the documentation would be found for the monitoring of Resident # 002.
Staff # 100, 101, 102 and Staff # 103 confirmed that there were no q 15 minute checks documented in POC, DOS or the progress notes for Resident # 002.

Inspector # 544 identified that Resident # 002 had two (2) RAI/MDS assessments completed and noted the assessments to be exactly the same. One was done before the incident and one after the incident. The RAI/MDS assessments identified a Cognitive Performance Scale Score of - 2- Cognitive Skills for decision- making were moderately impaired (even after the incident), although the plan of care identified that the responsive behaviours were escalating.

The licensee has failed to ensure that resident monitoring and internal reporting protocols are developed to meet the needs of residents with responsive behaviours.

2. Inspector # 544 reviewed a Critical Incident Report submitted to the Director by the home.
Inspector identified that in the first submission of The Critical Incident Report and the amended Critical Incident Report, it is written, Resident # 002 "remains on q 15 minute checks and will continue to be monitored for any behaviours."
Inspector # 544 could not find any documentation of the 15 minute checks in Point of Care (POC), Dementia Observation System (DOS) or Resident # 002's progress notes.
Staff # 100, 101, 102 and Staff #103 stated that this was where the documentation would be found for the monitoring of Resident # 002.
Staff # 100, 101, 102 and Staff # 103 confirmed that there were no q 15 minute checks documented in POC, DOS or the progress notes for Resident # 002 from

June 28, 2014 to July 11, 2014 or the present time.

Resident # 002's care plan did not identify the need to check Resident # 002 q 15 minutes immediately after the incident as written in the amended CI. The only change to the care plan was a few weeks after the incident, where it was written, "if Resident # 002 is yelling for staff to remove other Residents, staff need to redirect Resident # 002 to their room so they can spend time alone. If they are resistant to leaving the area, the other Residents must be moved for their safety, notify Registered Staff."

The home sent a referral for assessment on the attending physician's behalf, to a physician with the Canadian Mental Health Association in 2013, regarding Resident # 002's Responsive Behaviours.
Inspector could find no documentation regarding the status of this referral. There was no documentation in Resident # 002's health care record of this assessment being completed. It was confirmed by Staff # 100 that Resident # 002 had not yet be assessed by the physician from the Canadian Mental Health Association now thirteen (13) months after the incident.

The home sent a referral to Behavioural Supports Ontario (BSO) and it was re-faxed three (3) weeks later so that an assessment could be completed for Resident # 002. There was no documentation on Resident # 002's health care record to confirm that this referral or assessment was completed. This was also confirmed by Staff # 100.
The Administrator told Inspector # 544 that they thought BSO had completed an assessment for Resident # 002. Inspector requested, from the Administrator, the assessment report from BSO as it was not in Resident # 002's health care record. The Administrator faxed, to the Sudbury Service Area Office, a report from BSO with a report completion date of two and half (2 1/2) months after the incident. The initial BSO assessment for Resident # 002 was identified as occurring six (6) weeks after the incident. There were a number of recommendations included in this report regarding the management of Resident # 002's responsive behaviours however, they did not become part of Resident # 002's plan of care as the report from BSO was not sent to the home until two and half, (2 1/2) months after the incident.

Inspector # 544 reviewed the Teck Pioneer Residence Nursing Policy:Section: Risk Management, Subject: Responsive Behaviours written July 25, 2013, it is written.

" The home is committed to ensuring the needs of teh resident with responsive behaviours are met and the screening tools to be used are:
ABC Responsive behaviours documentation form
Cognitive Performance Scale
Montreal Cognitive Assessment (MoCA)
Folstein Mini Mental Exam

Inspector # 544 reviewed Resident # 002's health acre record and could not find a MoCA or a Folstein Mini mental exam completed for Resident # 002.

Inspector # 544 reviewed "The ABC Responsive Behaviours documentation form" for Resident # 002 and found it was incomplete and did not address the q15 minute checks that were to be completed for Resident # 002.

The policy,, Teck Pioneer Residence Nursing Policy: Section: Risk Management, Subject: Responsive Behaviours written July 25, 2013, also addressed referral protocols for Residents with responsive behaviours.

A referral was sent to a physician with the Canadian Mental Health Association to assess Resident # 002 in 2013. There was no documentation on Resident # 002's health care record or plan of care to identify that Resident # 002 was assessed by a physician from The Canadian Mental Health Association now thirteen (13) months after the incident. A referral was re-faxed one (1) week after the incident occurred to Behavioural Support Ontario (BSO). There was no documentation on Resident # 002's health care record or plan of care to confirm that this referral or assessment was completed by BSO for Resident # 002. The Administrator thought that an assessment was completed by BSO. Inspector # 544 requested, from the Administrator, the assessment report from BSO. The initial assessment report was dated six (6) weeks after the incident. The report was completed two and Half (2 1/2) months after the incident and was sent to the home one several days later. There were a number of recommendations in this report, however, they did not become part of Resident # 002's plan of care as the report was not on Resident # 002's health care record until two and half (2 1/2) months after the incident.

There was no documentation on Resident # 002's health care record to identify that Resident # 002 was assessed by a Geriatrician, a Geriatric Psychiatrist or a Psychogeriatrics Resource Consultant to assist in providing support and recommendations in dealing with Resident # 002's Responsive Behaviours as

identified in their policy above.

Inspector # 544 reviewed Resident # 002's progress notes for several months which identified that Resident # 002's Responsive Behaviours were present on their admission and were escalating to the present time.

The licensee has failed to ensure that the home's programs and services are integrated into the care that is provided to residents with responsive behaviours, is based on the assessed needs of residents with responsive behaviours and co-ordinated and implemented on an interdisciplinary basis.

3. The home instituted their Responsive Behaviours Program in July 2013. Inspector # 544 could not find any documentation that the Responsive Behaviours Program was evaluated in the last year.

The home's policy regarding Responsive Behaviours stated under Program Evaluation: "Annually, the Responsive Behaviour policy including screening protocols, assessments and re-assessment tools, will be evaluated by the Best Practice committee."
Staff # 100, 101 and Staff # 102 confirmed that this evaluation of the policy had not been done.

The licensee has failed to ensure that the responsive behaviours program has been evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

4. A referral for assessment was sent by the home on behalf of the attending physician to a physician with the Canadian Mental Health Association in 2013, regarding Resident # 002's Responsive Behaviours.
Inspector could find no documentation in Resident # 002's health care record regarding the status of this referral and/or reply from Canadian Mental Health Association's physician.
Staff # 100 confirmed that the Mental Health Association physician had not yet assessed Resident # 002. A follow up by the home regarding the status of this referral was not conducted by the home now thirteen (13) months later.

A referral for assessment regarding Resident # 002's escalating responsive behaviours was sent by the home to Behavioural Support Ontario (BSO) and it was then re-faxed one month after the incident. There was no documentation on

Resident # 002's health care record that this referral or assessment was completed.
The Administrator told Inspector that she thought the BSO assessment was completed.
Inspector # 544, requested, from the Administrator, the assessment report from BSO as it was not in Resident # 002's health care record.
The Administrator faxed to, the Sudbury Service Area Office a report from BSO with a completion date of two and half (2 1/2) months after the incident. The report identified that an initial assessment by BSO was completed for Resident # 002 six (6) weeks after the incident. There were a number of recommendations in this report however, they did not become part of Resident # 002's plan of care as the report was sent to the home several days after the report was completed. This was two and half (2 1/2) months after the incident.

The Critical Incident report submitted by the home to the Director identified that Resident # 002 was being monitored q 15 minutes after this incident. On the amended Critical Incident report submitted, it is written that Resident # 002 continued to be monitored q15 minutes.
Staff # 100, 101, 102 and Staff # 103 stated to Inspector that this documentation should be in DOS, (Dementia Observation System) or POC (Point of Care for the Personal Support Workers) documentation.
Inspector # 544 could not find any documentation of the 15 minute checks at any time in Point of Care (POC), Dementia Observation System (DOS) or Resident # 002's progress notes.
Staff # 100, 101, 102 and Staff # 103 confirmed that there were no q 15 minute checks documented in POC, DOS or the progress notes for Resident # 002 from June 28, 2014 to July 11, 2014.

The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours. (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 16, 2015

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. 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 ensure that Residents exhibiting responsive behaviours are assessed, referrals made and their plan of care is updated to reflect strategies to manage responsive behaviours in order that Residents are protected from abuse by anyone.

Grounds / Motifs :

1. Inspector # 544 reviewed a Critical Incident Report submitted to the Director by the home.
It is alleged that Resident # 001 was pushed by Resident # 002. Resident # 001 sustained injuries that resulted in their death.

Inspector identified that in the first submission of the Critical Incident Report and the amended Critical Incident Report, it is written, Resident # 002 "remains on q15 minute checks and will continued to be monitored for any behaviours."

Inspector # 544 could not find any documentation of the15 minute checks at any time in Point of Care (POC), Dementia Observation System (DOS) or progress notes.
Staff # 100, 101, 102 and Staff #103 stated that this was where the documentation was to be found for the monitoring of Resident # 002.
Staff # 100, 101, 102 and Staff # 103 confirmed that there were no q 15 minute checks documented in POC, DOS or the progress notes for Resident # 002.

The only change to Resident # 002's plan of care was, "to give the medications as ordered by the physician to assist with Resident # 002's responsive behaviours, staff will monitor for responsive behaviours and notify Registered Staff immediately if Resident # 002's behaviour is escalating." "If Resident # 002

is yelling, staff are to remove other Residents and redirect Resident # 002 to their room so they can spend time alone. If Resident # 002 is resistant to leaving the area, other Residents must be removed for their safety." There were no other directions in the plan of care regarding the management of Resident # 002's behaviours.

There was no clear direction to staff, in the plan of care, in regards the monitoring Resident # 002, where to chart the behaviours and how often to monitor Resident # 002. The care plan was not revised immediately following the incident as per the home's responsive behaviours policy. The care plan did not include the monitoring regime for Resident # 002 or recommendations from the Behavioural Support Ontario (BSO) report.

2. Inspector # 544 reviewed Resident # 002's progress notes and identified that Resident # 002's responsive behaviours were escalating and that they were exhibited since Resident # 002's admission as identified in Resident # 002's progress notes.

Inspector # 544 reviewed the Teck Pioneer Residence Nursing Policy: Section Risk Management, Subject: Responsive Behaviours written July 25, 2013 and identified that it is written, " The home is committed to ensuring the needs of residents with Responsive Behaviours are met."
The screening tools to be used are:
ABC Responsive Behaviours documentation form
Cognitive Performance Scale
Montreal Cognitive Assessment (MoCA)
Folstein Mini Mental State Exam

Inspector reviewed Resident # 002's health care record and could not find a Montreal Cognitive Assessment (MoCA) or a Folstein mini mental exam completed on Resident # 002.
The ABC Responsive Behaviours documentation form was incomplete. The charting on the ABC Recording: Challenging Behaviours was incomplete.
This was confirmed by Staff # 102 and Staff # 103.

The Responsive Behaviours Policy also addressed referral protocols for Residents who exhibit responsive behaviours. Inspector # 544 could find no documentation in Resident # 002's health care record to confirm that Resident # 002 had been assessed by a physician with the Mental Health Association, a

Psychogeriatrics Resource Consultant, BSO, a Community Outreach Program, a Geriatrician or a Geriatric Psychiatrist to assist in providing support and recommendations in dealing with Resident # 002's responsive behaviours as per the home's policy above.

A referral for assessment was sent by the home on behalf of the attending physician, to a physician with the Canadian Mental Health Association in 2013, regarding Resident # 002's Responsive Behaviours in 2013. Inspector could find no documentation in Resident # 002's health care record regarding the status of this referral and/or reply from the Canadian Mental Health Association's physician. It was confirmed by Staff # 100 that Resident # 002 had not yet been assessed by The Canadian Mental Health Association's physician. A follow up by the home regarding the status of this referral was not conducted now thirteen (13) months after the incident.

The home sent a referral to BSO and it was re-faxed one (1) month after the incident. There was no documentation on Resident # 002's health care record that this referral or assessment was completed. The Administrator told Inspector # 544 that she thought an assessment by BSO had been completed. Inspector # 544 requested, from the Administrator, the assessment report from BSO as it was not in Resident # 002's health care record. The Administrator faxed, to the Sudbury Service Area Office, a report from BSO. The report identified that an initial assessment was completed for Resident # 002 six (6) weeks after the incident. There were a number of recommendations in this report however, they did not become part of Resident # 002's plan of care as the report was sent to the home two and half (2 1/2) months after the incident.

Under Education in the Responsive Behaviours Program it is written:
1. " New staff, registered staff and all PSWs will receive education re: Management of Responsive Behaviours during orientation
2. Staff education sessions regarding Responsive Behaviour management will be provided annually and periodically as needed to assist all employees in understanding residents with cognitive impairment and responding to disruptive behaviour
3. Front line staff will be encouraged to attend GPA training
4. All staff, contractors and volunteers providing direct care must be orientated prior to assuming their job responsibilities and retraining annually in caring for persons with responsive behaviours and behaviour management."

Inspector # 544 identified that only 75/84, direct care staff, were trained in Responsive Behaviours in 2013.
Even though the Responsive Behaviours Program identified annual education for all staff, only 75/95 of all staff were provided with training in 2013.

Resident # 002 had a history of responsive behaviours which were documented to be escalating as per their progress notes.
A referral for assessment to a physician with the Canadian Mental Health Association in 2013, was not completed. A referral to BSO was completed six (6) weeks after the incident however, the recommendations were not part of Resident # 002's plan of care as the report was sent to the home two and half (2 1/2) months after the incident. The amended CI identified q15 minute checks however, this intervention was not identified in Resident # 002's care plan.

Thus, the licensee failed to protect Resident # 001 by Resident # 002 by ensuring that Residents exhibiting responsive behaviours are assessed, referrals made and their plan of care is updated to reflect strategies to manage responsive behaviours in order that Residents are protected from abuse by anyone. (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 16, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

> Directeur
> a/s Coordinateur des appels
> Direction de l'amélioration de la performance et de la conformité
> Ministère de la Santé et des Soins de longue durée
> 1075, rue Bay, 11e étage
> Ontario, ON
> M5S-2B1
> Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 9th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Franca McMillan

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