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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 7, 2014	2014_380593_0016	S-006187-14	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

BETHAMMI NURSING HOME
63 CARRIE STREET THUNDER BAY ON P7A 4J2

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 06th - 10th, 14th - 17th, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Dietary Staff, Activation Staff, Personal Support Workers (PSW), Residents and family members.

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

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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. This non-compliance is supported by the following findings:

Three complaints were received by the Ministry of Health and Long-Term Care in relation to a resident in the home exhibiting disruptive responsive behaviours. Each complainant has a family member residing in the home and have expressed that the behaviours of Resident #001 are negatively affecting the quality of life of their family members within the home.

A review of Resident #001's health care record found that Resident #001 has had no changes with their negative moods. Their anger is a concern as they can be unpleasant to other residents and staff. They are at risk for their safety and the safety of others. Resident #001 continues to be verbally and socially inappropriate.

Inspector's #593, #577 and #597 were in the home for two weeks during October, 2014 for a Resident Quality Inspection. During this time, all three inspectors observed Resident #001 continuously exhibiting disruptive responsive behaviours throughout the day while in their room, the dining room and any other area that the resident was residing.

Inspector #593 observed during the evening meal service in the dining room during an evening meal in October, 2014 the following:

17:35 Resident #001 is observed to exhibit responsive behaviours. Resident #002 is observed to tell Resident #001 "shut-up", to which Resident #001 replied "no, you shut

up", followed by Resident #002 further saying "no, you shut up". A staff member is observed seated at Resident #001’s table however they are assisting another resident at this time. Resident #001 continues to exhibit responsive behaviours to which staff are not responding at this time.

17:38 A staff member is observed to advise Resident #001 that they will provide them assistance with their meal, the staff member is then observed to leave and Resident #001 has recommenced the responsive behaviours.

17:41 A staff member is observed to sit next to Resident #001 and advise that they will help, Resident #001 has responded with "thank-you". The staff member is then observed to leave the table and Resident #001 has recommenced the responsive behaviours. Resident #003 is observed to yell out "be quiet".

Inspector #593 observed during the lunch meal service in the dining room during October, 2014 the following:

12:14 Resident #001 is observed to be exhibiting responsive behaviours. A staff member is observed to tell Resident #001 that they have to feed another resident and then leave Resident #001. Resident #001 recommences the responsive behaviours.

12:15 Resident #001 continues to exhibit responsive behaviours. No staff members are observed to approach Resident #001 at this time.

12:20 A staff member is observed to be seated next to Resident #001 to assist with feeding and Resident #001 has settled.

12:28 The staff member is observed to leave Resident #001’s table who has recommenced exhibiting responsive behaviours. Resident #002 from another table is observed to yell towards Resident #001 who has responded verbally. The staff member has returned to the table to feed Resident #001 dessert who is now settled.

12:35 A staff member is observed to remove Resident #001 from the dining room.

12:50 Resident #001 is observed to be in bed now for the past 15 minutes, they have continued to exhibit responsive behaviours. Staff members within the home have not intervened during this time.

Inspector #593 observed during the evening meal service in the dining room during October 2014, the following:

17:26 Verbal exchanges between Residents #001, #003 and #004 while Resident #001 is exhibiting disruptive responsive behaviours.

17:29 A meal is provided to Resident #001 who has started to eat.

17:32 Resident #001 has recommenced the responsive beahviours. A staff member is observed to tell Resident #001 that they will be over shortly to help her and Resident #001 settles and for the next 30 minuites exhibits disruptive responsive behaviours while a staff member provides feeding assistance.

During an interview with Inspector #593 October 15, 2014, staff member #100 advised that Resident #001 exhibits disruptive responsive behaviours at every meal, in bed and across all shifts every day of the week. Regarding managing these disruptive behaviours, they advised that the home have tried music and other activities but this does not seem to work. The staff member advised that Resident #001 seems to be happier and to calm down when they are with another person. In addition, staff member #100 advised that Resident #001 is alert and responsive and understands the comments that are made to them by other residents within the home. They advised that Residents #003, #006 and #007 are usually the residents that respond to Resident #001's responsive behaviours in the dining room.

During an interview with inspector #593 October 15, 2014, staff member #101 advised that Resident #001's behaviour has been occurring since admission to the home over a year earlier. Regarding interventions for this behaviour, staff member #101 advised that they have tried keeping Resident #001 in their room at meals however Resident #001 likes to be in the dining room at mealtimes. In addition, they have tried to distract the resident and move them around the unit however this does not seem to work. They further advised that the resident was in a different home before admission to this home and the behaviours were not evident in this previous home.

During an interview with Inspector #593 October 17, 2014; staff member #102 advised that Resident #001 is always disruptive in the dining room during meal times. They further advised that they often provide feeding assistance to Resident #001 during meals and this can help with settling of their disruptive behaviours. Regarding management of the disruptive behaviours, staff member #102 advised that they try to distract Resident

#001 which does work sometimes however this is not part of the resident's plan of care or a directive from the home.

During an interview with Inspector #593 October 15, 2014, staff member #103 advised that Resident #001’s behaviours are an ongoing issue of which there appears to be no pattern; they have removed the resident from the dining room when they have been upsetting other residents however they try not to do this too often as Resident #001 likes to have their meals in the dining room. In addition, the nursing care approach is minimally effective as was adjusting medications. Staff member #103 advised that a referral to BSO had been submitted, however BSO will not proceed until they have blood work and they have been unable to obtain blood from Resident #001 at this time. Furthermore the home has now recruited a volunteer who spend one on one time with Resident #001.

During an interview with Inspector #593 October 15, 2014, the Administrator advised that Resident #001’s behaviours have been an issue in the home since they were first admitted. They further advised that they have tried many strategies to manage these behaviours with minimal results. The Administrator added that they believe that a medical specialist has been involved however they are unsure of the details regarding this however this information can be found in the resident's health care record.

A review of Resident #001’s health care record by Inspector #593 found no involvement in the resident's care by a medical specialist or any other discipline specialising in dealing with responsive behaviours. In addition, the resident's physician reviewed the resident's medication in relation to the resident's behaviours however there are no further notes or orders that this has been reviewed by the physician since this date.

A review of Resident #001’s progress notes found the following:

"Resident spent the major part of the evening exhibiting responsive behaviours. Emotional support provided throughout shift by many different staff with very little effect of calming down the resident".

"Resident has been exhibiting responsive behaviours since the start of the evening shift. They will not stop and were given medication to see if there was any underlying discomfort that they could not express. There was no change in behaviour 1.5 hours later".

"Spoke with NP yesterday regarding resident's increased behaviours, they ordered a

medical test and started the resident on medication".

Over several months and across all shifts, Resident #001 continued to display disruptive responsive behaviours despite prescribed medication being administered by registered nursing staff.

A review of Resident #001's most recent plan of care found the following directives:

- Please ensure that resident does not get trays in room, needs encouragement to go to dining room for all meals
- Observe, document and report to physician S&S of delirium; altered mental status, wide variation in congitive functioning thought course of day, communication decline, disorientation, restlessness/agitation and altered sleep cycles
- Re-direct and provide gentle reality orientation PRN
- All staff to introduce themselves each time they approach resident
- Be consistent with staff and routines
- Identify yourself at all times and attempt to maintain eye contact
- Use a gentle approach with an open friendly relaxed manner and expression
- Use questions that require a yes/no response
- Approach using a calm, non-threatening manner
- Assess the residents ability to understand/control the behavior
- Avoid positive reinforcement of negative behaviors
- Take resident to a quiet area where they can vent their frustration without disturbing others
- Provide resident with undivided attention each shift; does well with one-on-one attention
- Seek out and determine whereabouts
- When resident is exhibiting this behavior staff to leave resident and return in 10 minutes
- Avoid any conversations that may encourage or initiate inappropriate behavior
- Set limits for acceptable behavior
- If resident can tolerate, explain how their behavior makes you feel
- Staff take time each shift to establish and maintain a trusting relationship in order to diminish potential behaviors from taking hold
- Be consistent with approach to resident
- Help resident to express feelings to work through any anger or fear that they may have
- Continue to monitor report and record behavior for successful and unsuccessful

interventions
• Provide one to one visits with resident, visits, games, baking, walks, provide music in their room

A review of the home's policy "Responsive Behaviour Program" 3-50 dated May 2012 found that the responsive behaviour program utilizes a coordinated inter-professional approach to develop, implement, monitor and evaluate strategies that prevent or minimize situations in which a Resident exhibits responsive behaviours.

The behaviours exhibited during the two weeks inspectors were in the home were met with little response from staff within the home. Inconsistent approaches were verbalised by staff and observed by inspectors within the home. Health professionals specializing in responsive behaviours have yet to be involved with this resident. Family members of residents in the home have made complaints relating to the resident's behaviour affecting their family member's quality of life within the home and this was observed during meal times in the home when the resident's behaviours were met with negative responses voiced by other residents observed to be frustrated and aggravated by the behaviours of Resident #001. The home has not been consistent with their policy which states that "the responsive behaviour program at Bethammi utilizes a coordinated inter-professional approach to develop, implement, monitor and evaluate strategies that prevent or minimize situations in which a resident exhibits responsive behaviours". The resident has been displaying responsive behaviours for over one year since admission and the resident's behaviours are not documented on a daily basis or by each shift nor is the action taken and response documented when and if dealing with the resident's responsive behaviours.

As evidenced by observations, interviews with family members and staff and review of Resident #001's health care records; Resident #001 is displaying ongoing disruptive responsive behaviours in the home that are affecting the quality of life of other residents within the home. As such, the licensee has failed to identify the behavioural triggers for the resident, develop and implement strategies to respond to these behaviours consistently and take action to respond to the needs of the resident, including assessments, reassessments and interventions and that the residents responses to interventions are documented. [s. 53. (4) (c)]

Additional Required Actions:

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

Issued on this 11th day of January, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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) :	GILLIAN CHAMBERLIN (593)
Inspection No. / No de l'inspection :	2014_380593_0016
Log No. / Registre no:	S-006187-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 7, 2014
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	BETHAMMI NURSING HOME 63 CARRIE STREET, THUNDER BAY, ON, P7A-4J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Meaghan Sharp

To ST. JOSEPH'S CARE GROUP, 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under O.Reg. 79/10, s.53 (4). This plan is to include:

1. Steps undertaken in utilizing a coordinated inter-professional approach to develop, implement, monitor and evaluate strategies that prevent or minimize situations in which a Resident, specifically Resident #001, exhibits responsive behaviours.

2. Identification of the behavioral triggers for Resident #001, how these triggers are minimized and the response taken by each staff discipline when triggers are present.

3. Responsibilities of each staff discipline in identifying, monitoring, managing and documenting behaviours exhibited by Resident #001.

4. Strategies undertaken to minimize impact of disruptive responsive behaviours upon other Residents within the home ensuring the quality of life for Residents is not negatively impacted.

5. Strategies undertaken to engage Resident #001 regularly in a variety of scheduled and non-scheduled activities ensuring regular social stimulation to prevent anxiety and feelings of isolation.

6. Continuous monitoring of the above steps to ensure that the plan is relevant if/when contributing factors change.

This plan is to be submitted to Gillian Chamberlin, Long-Term Care Homes Inspector. Ministry of Health and Long-Term Care, gillian.chamberlin@ontario.ca by November 21st, 2014.

Grounds / Motifs :

1. 1. This non-compliance is supported by the following findings:

Three complaints were received by the Ministry of Health and Long-Term Care in relation to a resident in the home exhibiting disruptive responsive behaviours. Each complainant has a family member residing in the home and have expressed that the behaviours of Resident #001 are negatively affecting the quality of life of their family members within the home.

A review of Resident #001's health care record found that Resident #001 has had no changes with their negative moods. Their anger is a concern as they can be unpleasant to other residents and staff. They are at risk for their safety and the safety of others. Resident #001 continues to be verbally and socially inappropriate.

Inspector's #593, #577 and #597 were in the home for two weeks during October, 2014 for a Resident Quality Inspection. During this time, all three inspectors observed Resident #001 continuously exhibiting disruptive responsive behaviours throughout the day while in their room, the dining room and any other area that the resident was residing.

Inspector #593 observed during the evening meal service in the dining room during an evening meal in October, 2014 the following:

17:35 Resident #001 is observed to exhibit responsive behaviours. Resident #002 is observed to tell Resident #001 "shut-up", to which Resident #001 replied "no, you shut up", followed by Resident #002 further saying "no, you shut up". A staff member is observed seated at Resident #001's table however they are assisting another resident at this time. Resident #001 continues to exhibit responsive behaviours to which staff are not responding at this time.

17:38 A staff member is observed to advise Resident #001 that they will provide them assistance with their meal, the staff member is then observed to leave and Resident #001 has recommenced the responsive behaviours.

17:41 A staff member is observed to sit next to Resident #001 and advise that they will help, Resident #001 has responded with "thank-you". The staff member is then observed to leave the table and Resident #001 has recommenced the responsive behaviours. Resident #003 is observed to yell out "be quiet".

Inspector #593 observed during the lunch meal service in the dining room during October, 2014 the following:

12:14 Resident #001 is observed to be exhibiting responsive behaviours. A staff member is observed to tell Resident #001 that they have to feed another resident and then leave Resident #001. Resident #001 recommences the responsive behaviours.

12:15 Resident #001 continues to exhibit responsive behaviours. No staff members are observed to approach Resident #001 at this time.

12:20 A staff member is observed to be seated next to Resident #001 to assist with feeding and Resident #001 has settled.

12:28 The staff member is observed to leave Resident #001's table who has recommenced exhibiting responsive behaviours. Resident #002 from another table is observed to yell towards Resident #001 who has responded verbally. The staff member has returned to the table to feed Resident #001 dessert who is now settled.

12:35 A staff member is observed to remove Resident #001 from the dining room.

12:50 Resident #001 is observed to be in bed now for the past 15 minutes, they have continued to exhibit responsive behaviours. Staff members within the home have not intervened during this time.

Inspector #593 observed during the evening meal service in the dining room during October 2014, the following:

17:26 Verbal exchanges between Residents #001, #003 and #004 while Resident #001 is exhibiting disruptive responsive behaviours.

17:29 A meal is provided to Resident #001 who has started to eat.

17:32 Resident #001 has recommenced the responsive beahviours. A staff member is observed to tell Resident #001 that they will be over shortly to help her and Resident #001 settles and for the next 30 minuites exhibits disruptive responsive behaviours while a staff member provides feeding assistance.

During an interview with Inspector #593 October 15, 2014, staff member #100 advised that Resident #001 exhibits disruptive responsive behaviours at every meal, in bed and across all shifts every day of the week. Regarding managing these disruptive behaviours, they advised that the home have tried music and other activities but this does not seem to work. The staff member advised that Resident #001 seems to be happier and to calm down when they are with another person. In addition, staff member #100 advised that Resident #001 is

alert and responsive and understands the comments that are made to them by other residents within the home. They advised that Residents #003, #006 and #007 are usually the residents that respond to Resident #001's responsive behaviours in the dining room.

During an interview with inspector #593 October 15, 2014, staff member #101 advised that Resident #001's behaviour has been occurring since admission to the home over a year earlier. Regarding interventions for this behaviour, staff member #101 advised that they have tried keeping Resident #001 in their room at meals however Resident #001 likes to be in the dining room at mealtimes. In addition, they have tried to distract the resident and move them around the unit however this does not seem to work. They further advised that the resident was in a different home before admission to this home and the behaviours were not evident in this previous home.

During an interview with Inspector #593 October 17, 2014; staff member #102 advised that Resident #001 is always disruptive in the dining room during meal times. They further advised that they often provide feeding assistance to Resident #001 during meals and this can help with settling of their disruptive behaviours. Regarding management of the disruptive behaviours, staff member #102 advised that they try to distract Resident #001 which does work sometimes however this is not part of the resident's plan of care or a directive from the home.

During an interview with Inspector #593 October 15, 2014, staff member #103 advised that Resident #001's behaviours are an ongoing issue of which there appears to be no pattern; they have removed the resident from the dining room when they have been upsetting other residents however they try not to do this too often as Resident #001 likes to have their meals in the dining room. In addition, the nursing care approach is minimally effective as was adjusting medications. Staff member #103 advised that a referral to BSO had been submitted, however BSO will not proceed until they have blood work and they have been unable to obtain blood from Resident #001 at this time. Furthermore the home has now recruited a volunteer who spend one on one time with Resident #001.

During an interview with Inspector #593 October 15, 2014, the Administrator advised that Resident #001's behaviours have been an issue in the home since they were first admitted. They further advised that they have tried many

strategies to manage these behaviours with minimal results. The Administrator added that they believe that a medical specialist has been involved however they are unsure of the details regarding this however this information can be found in the resident's health care record.

A review of Resident #001's health care record by Inspector #593 found no involvement in the resident's care by a medical specialist or any other discipline specialising in dealing with responsive behaviours. In addition, the resident's physician reviewed the resident's medication in relation to the resident's behaviours however there are no further notes or orders that this has been reviewed by the physician since this date.

A review of Resident #001's progress notes found the following:

"Resident spent the major part of the evening exhibiting responsive behaviours. Emotional support provided throughout shift by many different staff with very little effect of calming down the resident".

"Resident has been exhibiting responsive behaviours since the start of the evening shift. They will not stop and were given medication to see if there was any underlying discomfort that they could not express. There was no change in behaviour 1.5 hours later".

"Spoke with NP yesterday regarding resident's increased behaviours, they ordered a medical test and started the resident on medication".

Over several months and across all shifts, Resident #001 continued to display disruptive responsive behaviours despite prescribed medication being administered by registered nursing staff.

A review of Resident #001's most recent plan of care found the following directives:

• Please ensure that resident does not get trays in room, needs encouragement to go to
dining room for all meals
• Observe, document and report to physician S&S of delirium; altered mental status,
wide variation in congitive functioning thought course of day,

communication decline,
disorientation, restlessness/agitation and altered sleep cycles
• Re-direct and provide gentle reality orientation PRN
• All staff to introduce themselves each time they approach resident
• Be consistent with staff and routines
• Identify yourself at all times and attempt to maintain eye contact
• Use a gentle approach with an open friendly relaxed manner and expression
• Use questions that require a yes/no response
• Approach using a calm, non-threatening manner
• Assess the residents ability to understand/control the behavior
• Avoid positive reinforcement of negative behaviors
• Take resident to a quiet area where they can vent their frustration without disturbing others
• Provide resident with undivided attention each shift; does well with one-on-one attention
• Seek out and determine whereabouts
• When resident is exhibiting this behavior staff to leave resident and return in 10 minutes
• Avoid any conversations that may encourage or initiate inappropriate behavior
• Set limits for acceptable behavior
• If resident can tolerate, explain how their behavior makes you feel
• Staff take time each shift to establish and maintain a trusting relationship in order to diminish potential behaviors from taking hold
• Be consistent with approach to resident
• Help resident to express feelings to work through any anger or fear that they may have
• Continue to monitor report and record behavior for successful and unsuccessful interventions
• Provide one to one visits with resident, visits, games, baking, walks, provide music in their room

A review of the home's policy "Responsive Behaviour Program" 3-50 dated May 2012 found that the responsive behaviour program utilizes a coordinated inter-professional approach to develop, implement, monitor and evaluate strategies that prevent or minimize situations in which a Resident exhibits responsive

behaviours.

The behaviours exhibited during the two weeks inspectors were in the home were met with little response from staff within the home. Inconsistent approaches were verbalised by staff and observed by inspectors within the home. Health professionals specializing in responsive behaviours have yet to be involved with this resident. Family members of residents in the home have made complaints relating to the resident's behaviour affecting their family member's quality of life within the home and this was observed during meal times in the home when the resident's behaviours were met with negative responses voiced by other residents observed to be frustrated and aggravated by the behaviours of Resident #001. The home has not been consistent with their policy which states that "the responsive behaviour program at Bethammi utilizes a coordinated inter-professional approach to develop, implement, monitor and evaluate strategies that prevent or minimize situations in which a resident exhibits responsive behaviours". The resident has been displaying responsive behaviours for over one year since admission and the resident's behaviours are not documented on a daily basis or by each shift nor is the action taken and response documented when and if dealing with the resident's responsive behaviours.

As evidenced by observations, interviews with family members and staff and review of Resident #001's health care records; Resident #001 is displaying ongoing disruptive responsive behaviours in the home that are affecting the quality of life of other residents within the home. As such, the licensee has failed to identify the behavioural triggers for the resident, develop and implement strategies to respond to these behaviours consistently and take action to respond to the needs of the resident, including assessments, reassessments and interventions and that the residents responses to interventions are documented. [s. 53. (4) (c)] (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 07, 2014

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

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 7th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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