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) :	KELLY-JEAN SCHIENBEIN (158)
Inspection No. / No de l'inspection :	2012_140158_0010
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Aug 2, 3, 8, 13, 15, 16, 17, Sep 7, 2012
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE FALCONBRIDGE 281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JAMES R. FOREMAN

To EXTENDICARE (CANADA) INC., 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)

Linked to Existing Order / Lien vers ordre existant: 2012_139163_0017, CO #001

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that plans of care for all residents who exhibit responsive behaviours provide clear directions regarding management of these responsive behaviours to staff and others who provide direct care to residents. The plan shall be submitted to Kelly-Jean Schienbein, LTC Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury ON, P3E 6AE (Fax# 705-564-3133) by September 14, 2012.

Grounds / Motifs :

1. The Inspector reviewed the health care record including the plan of care for resident # 05 on August 02/12. The progress notes identified that on June 3/12 " a big tall person came into their room during the night and put their hands around resident # 05 throat". It was identified in the progress notes that resident # 05 was agitated and yelling. The resident's neck was also observed by RPN to have petechiae and that the resident was guarding their neck area when the RN attempted to assess the area. The RN reported to the DOC that the resident was frightened. The resident's plan of care was reviewed by the Inspector on August 2/12. Fearful behaviours and subsequent interventions to address them were not documented. Staff # 105 identified that resident # 05 still has fearful periods. Resident # 05 was guarded and appeared fearful when the Inspector approached the resident on Aug 7/12. The plan of care does not set out clear directions to staff and others who provide direct care to resident # 05. [LTCHA 2007, S.O. 2007, s. 6. (1) (c)] (158)
2. The Inspector reviewed the health care record including the plan of care for resident # 08 on August 07/12. The progress notes identified that when resident # 08 was sitting in the dining room watching TV, resident # 07 forcefully took the remote from resident # 08. Resident # 08 stated that they were wanting to press charges against resident # 07. The administrator met with resident # 08 and identified that resident # 07 wanted to apologize which was declined. The progress notes identified that resident # 08 required comforting strategies post incident. There was no further documentation regarding the incident in the progress notes.
Resident # 08 identified to the inspector on August 3, 7 and 8/12 that they still wanted to press charges and remains fearful of resident # 07.
The plan of care for resident # 08 was reviewed on August 7/12. Although, there is a plan of care related to anxiousness and anger, there is no mention of fear and anxiety or interventions to manage the behaviours that resulted from resident # 07 forcibly removing the remote.
The plan of care does not set out clear directions to staff and others who provide direct care to resident # 08. [LTCHA 2007, S.O. 2007, s. 6. (1) (c)] (158)
3. The Inspector reviewed the health care record including the plan of care for resident # 04 on August 07/12. The fluid flow sheets from July 25/12 to August 2/12 were reviewed by the Inspector. The codes 97 and 98 were consistently documented for the nourishment pass. Staff # 108 identified on August 2/12 that codes 97 and 98 are used when a resident refuses the nourishment. Staff # 108 stated that resident # 04 refuses all the time. The

resident's plan of care does not address the resident's ongoing refusal of nourishment nor provide any direction on how to manage the behaviour. The plan of care does not set out clear directions to staff and others who provide direct care to resident # 04. [LTCHA 2007, S.O. 2007, s. 6.(1)(c)] (158)
4. The Inspector observed bingo on August 3/12 in the main activity room from 18:15hr to 20:00hr. The Inspector observed that resident # 07 became increasingly angry when they lost the game to other residents. Resident # 07 was heard by the Inspector to use foul language and make derogatory comments when a cognitively impaired resident # 09 asked the staff to review the bingo numbers that were called.
The Inspector spoke with staff # 109 on August 7/12. The staff member confirmed that resident # 07 becomes rude and is verbally inappropriate towards residents who are less cognitive especially when resident # 07 is losing at the game. Staff # 109 identified that they usually handles the situation and does not inform the staff on the floor unless the situation is not managed. Staff # 109 stated "oh that's just the resident ".The health care record including the plan of care for resident # 07 was reviewed by the Inspector on August 3/12. The plan of care identified that the resident is rude and becomes verbally/physically responsive when his needs are not met. Interventions included; guide resident out of the area, sit and talk about the problem; encourage resident to walk away and talk with staff. The plan of care does not identify that resident # 07 becomes verbally or emotionally abusive to cognitively impaired residents during activities such as bingo nor provides clear direction on how to manage the behaviour. The plan of care does not set out clear directions to staff and others who provide direct care to resident # 07. [LTCHA 2007, S.O. 2007, s. 6. (1) (c)] (158)
5. On August 02/12, the Inspector heard someone yelling " nurse help, nurse" at 16:30hr. The Inspector observed staff # 100 at the elevators yelling out, "help, the resident has my hands" (" refers to resident # 02). The Inspector observed that the resident's grip became stronger as staff # 100 continued to voice anxiety. Two other staff members arrived and the two staff pulled the hands of resident # 02 from staff # 100. The staff then left resident # 02 who was moaning, mumbling and rubbing their hands alone at the elevators. At 16:55hr, the Inspector observed several other residents enter the elevators to eat on the main level. The Inspector heard the residents questioning themselves whether "the person" referring to resident # 02 who was at the elevators was going to join them to go down to eat. The elevator doors were held opened but closed when resident # 02 neared the doors. Staff were not observed by the Inspector to be near the elevators or monitoring resident # 02. The Inspector reviewed the health care record including the plan of care for resident # 02 on August 02/12. Documentation in the progress notes identified that on July 28/12, resident # 02 who insisted on taking the elevator held onto the staff member's hands and would not let go. On August 01/12, there were three entries identifying the resident's attempt to exit the unit by way of the elevator during the evening shift. Staff # 101 confirmed on August 02/12 that the resident has been displaying exit seeking behaviours more often. Staff # 102 identified on August 02/12 to the Inspector that the resident's behaviours increased since the start of summer when the activity aides started to take the resident outside more often. Although the plan of care for resident # 02 identifies that the resident wanders and exit seeks, there are no interventions identified to redirect the resident away from the elevators or to manage the resident's physical responsiveness when attempts to deter the resident from entering the elevator occurs. The plan of care does not set out clear directions to staff and others who provide direct care to resident # 02 to manage the exit seeking behaviour. [LTCHA 2007, S.O. 2007, s. 6. (1) (c)] (158)
6. The Inspector observed resident # 03 sitting in the dining room yelling out profanities on August 3/12. The dietary staff and PSW who were near this room were observed by the Inspector to not respond or to address the resident's behaviour.
The health care record including the plan of care for resident # 03 was reviewed by the Inspector on August 3/12. The plan of care identified that the resident will make excessive noise, however, the type of noise is not identified. The plan of care also identified that the resident becomes physical aggressive and yells out during care delivery. There were no specific interventions identified to manage the resident's yelling out profanities when care is not provided. The plan of care does not set out clear directions to staff and others who provide direct care to resident # 03. [LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (c) (158)
7. The Inspector observed resident # 06 on an unit pacing and "asking how do I get out of here, I want to go home "from 09:30hr until 11:00hr on August 3/12. Staff # 112 and staff # 113 were observed by the Inspector to quickly redirect the resident then walk away. Resident # 06 was observed by the Inspector at 11:50hr to be standing just inside the main lobby on the ground floor for approximately 5 minutes. There was no staff present.

The resident was observed to exit out the first set of doors which set off the roam alert. Staff # 110 appeared and attempted to verbally redirect resident # 06, however, the resident was out the main doors which were key padded opened by a visitor and in the parking lot heading for the highway before staff # 110 caught up to the resident. Resident # 06 was combative and resistive to staff # 110. The Inspector then observed staff # 114 to call for assistance. Staff # 111 was observed by the Inspector to assist staff # 110. The Inspector returned to the resident's unit and noted that the RN had just been notified of resident # 06 having eloped from the building. Staff # 108 who was also on the unit was not aware the resident left. Staff # 105 stated to the Inspector that resident # 06 "always wants to go home but they do not go on the elevator on days and that the resident is always supervised when going off the floor". The health care record including the plan of care for resident # 06 was reviewed by the Inspector on August 3/12. The interventions for exit seeking reference the behaviour as occurring on evenings and nights and not during the day. There is a contradiction as to where the roam alert bracelet is applied and there are no interventions directing the management of the combativeness and resistive behaviour of resident # 06 when the resident has eloped outside. The plan of care does not set out clear direction to staff and others providing direct care to resident # 06 to manage the exit seeking behaviours. [LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (c)] (158)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 21, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 September, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KELLY-JEAN SCHIENBEIN

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

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 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 2, 3, 8, 13, 15, 16, 17, Sep 7, 2012	2012_140158_0010	Follow up

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Dietary Manager, the Dietitian, the Activity Manager, Registered staff, Personal Support Workers (PSWs), the Quality Assurance Co-ordinator, Activity aides, residents, families and visitors.

During the course of the inspection, the inspector(s) walked through resident home areas, observed staff to resident interactions and care, reviewed health care records, policies and procedures and staff education/training records. The following previously issued Compliance Order from inspection # 2012_139163_0017 was reviewed as part of this follow-up inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The Inspector observed resident # 06 on an unit pacing and "asking how do I get out of here, I want to go home" from 09:30hr until 11:00hr on August 3/12. Staff # 112 and staff # 113 were observed by the Inspector to quickly redirect the resident then walk away. Resident # 06 was observed by the Inspector at 11:50hr to be standing just inside the main lobby on the ground floor for approximately 5 minutes. There was no staff present. The resident was observed to exit out the first set of doors which set off the roam alert. Staff # 110 appeared and attempted to verbally redirect resident # 06, however, the resident was out the main doors which were key padded opened by a visitor and in the parking lot heading for the highway before staff # 110 caught up to the resident. Resident # 06 was combative and resistive to staff # 110. The Inspector then observed staff # 114 to call for assistance. Staff # 111 was observed by the Inspector to assist staff # 110. The Inspector returned to the resident's unit and noted that the RN had just been notified of resident # 06 having eloped from the building. Staff # 108 who was also on the unit was not aware the resident left. Staff # 105 stated to the Inspector that resident # 06 "always wants to go home but the resident does not go on the elevator on days and that the resident is always supervised when going off the floor". The health care record including the plan of care for resident # 06 was reviewed by the Inspector on August 3/12. The interventions for exit seeking reference the behaviour as occurring on evenings and nights and not during the day. There is a contradiction as to where the roam alert bracelet is applied and there are no interventions directing the management of the combativeness and resistive behaviour of resident # 06 when the resident has eloped outside. The plan of care does not set out clear direction to staff and others providing direct care to resident # 06 to manage the exit seeking behaviours. [LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (c)]
2. The Inspector observed resident # 03 sitting in the dining room yelling out profanities on August 3/12. The dietary staff and PSW who were near this room were observed by the Inspector to not respond or to address the resident's behaviour. The health care record including the plan of care for resident # 03 was reviewed by the Inspector on August 3/12. The plan of care identified that the resident will make excessive noise, however, the type of noise is not identified. The plan of care also identified that the resident becomes physical aggressive and yells out during care delivery. There were no specific interventions identified to manage the resident's yelling out profanities when care is not provided. The plan of care does not set out clear directions to staff and others who provide direct care to resident # 03. [LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (c)
3. On August 02/12, the Inspector heard someone yelling " nurse help, nurse" at 16:30hr. The Inspector observed staff # 100 at the elevators yelling out, "help, the resident has my hands". (refers to resident # 02). The Inspector observed that the resident's grip became stronger as staff # 100 continued to voice anxiety. Two other staff members arrived and the two staff pulled the hands of resident # 02 from staff # 100. The staff then left resident # 02 who was moaning, mumbling and rubbing their hands alone at the elevators. At 16:55hr, the Inspector observed several other residents enter the elevators to eat on the main level. The Inspector heard the residents questioning themselves whether "the person" referring to resident # 02 who was at the elevators was going to join them to go down to eat. The elevator doors were held opened but closed when resident # 02 neared the doors. Staff were not observed by the Inspector to be near the elevators or monitoring resident # 02. The Inspector reviewed the health care record including the plan of care for resident # 02 on August 02/12. Documentation in the progress notes identified that on July 28/12, resident # 02 who insisted on taking the elevator held onto the staff member's hands and would not let go. On August 01/12, there were three entries identifying the resident's attempt to exit the unit by way of the elevator during the evening shift. Staff # 101 confirmed on August 02/12 that the resident has been displaying exit seeking behaviours more often. Staff # 102 identified on August 02/12 to the Inspector that the resident's behaviours increased since the start of summer when the activity aides started to take the resident outside more often. Although the plan of care for resident # 02 identifies that the resident wanders and exit seeks, there are no interventions identified to redirect the resident away from the elevators or to manage the resident's physical responsiveness when attempts to deter the resident from entering the elevator occurs. The plan of care does not set out clear directions to staff and others who provide direct care to resident # 02 to manage the exit seeking behaviour. [LTCHA 2007, S.O. 2007, s. 6. (1) (c)]
4. The Inspector observed bingo on August 3/12 in the main activity room from 18:15hr to 20:00hr. The Inspector observed that resident # 07 became increasingly angry when the resident lost the game to other residents. Resident # 07 was heard by the Inspector to use foul language and make derogatory comments when a cognitively impaired resident # 09 asked the staff to review the bingo numbers that were called. The Inspector spoke with staff # 109 on August 7/12. The staff member confirmed that resident # 07 becomes rude and is verbally inappropriate towards residents who are less cognitive especially when resident # 07 is losing at the game. Staff # 109 identified that they usually handles the situation and does not inform the staff on the floor unless the situation is not managed. Staff # 109 stated "oh that's just the resident ".The health care record including the plan of care for resident # 07 was reviewed by the Inspector on August 3/12. The plan of care identified that the resident is rude and becomes verbally/physically responsive when the resident's needs are not met. Interventions included: guide resident out of the area, sit and talk

about the problem; encourage resident to walk away and talk with staff. The plan of care does not identify that resident # 07 becomes verbally or emotionally abusive to cognitively impaired residents during activities such as bingo nor provide clear direction on how to manage the behaviour. The plan of care does not set out clear directions to staff and others who provide direct care to resident # 07. [LTCHA 2007, S.O. 2007, s. 6. (1) (c)]
5. The Inspector reviewed the health care record including the plan of care for resident # 04 on August 07/12. The fluid flow sheets from July 25/12 to August 2/12 were reviewed by the Inspector. The codes 97 and 98 were consistently documented for a nourishment pass. Staff # 108 identified on August 2/12 that codes 97 and 98 are used when a resident refuses the nourishment. Staff # 108 stated that resident # 04 refuses all the time. The resident's plan of care does not address this resident's ongoing refusal of nourishment nor provide any direction on how to manage this behaviour. The plan of care does not set out clear directions to staff and others who provide direct care to resident # 04. [LTCHA 2007, S.O. 2007, s. 6.(1)(c)]
6. The Inspector reviewed the health care record including the plan of care for resident # 08 on August 07/12. The progress notes identified that when resident # 08 was sitting in the dining room watching TV, resident # 07 forcefully took the remote out of resident's # 08 hands. Resident # 08 stated that they wanted to press charges against resident # 07. The administrator met with resident # 08 and identified that resident # 07 wanted to apologize which resident # 08 declined. The progress notes identified that resident # 08 required comforting strategies post incident. There was no further documentation regarding the incident in the progress notes. Resident # 08 identified to the inspector on August 3, 7 and 8/12 that they still wanted to press charges and remains fearful of resident # 07. The plan of care for resident # 08 was reviewed on August 7/12. Although, there is a plan of care related to anxiousness and anger, there is no mention of fear and anxiety or interventions to manage the behaviours that resulted from resident # 07 forcibly removing the remote. The plan of care does not set out clear directions to staff and others who provide direct care to resident # 08. [LTCHA 2007, S.O. 2007, s. 6. (1) (c)]
7. The Inspector reviewed the health care record including the plan of care for resident # 05 on August 02/12. The progress notes identified that on June 3/12 " a big tall person came into the resident's room during the night and put their hands around resident # 05 throat". It was identified in the progress notes that resident # 05 was agitated and yelling. The resident's neck was also observed by the RPN to have petechiae and that the resident was guarding their neck area when the RN attempted to assess the area. The RN reported to the DOC that the resident was frightened. The resident's plan of care was reviewed by the Inspector on August 2/12. Fearful behaviours and subsequent interventions to address them were not documented. Staff # 105 identified that resident # 05 still has fearful periods. Resident # 05 was guarded and appeared fearful when the Inspector approached the resident on Aug 7/12. The plan of care does not set out clear directions to staff and others who provide direct care to resident # 05. [LTCHA 2007, S.O. 2007, s. 6. (1) (c)]

Additional Required Actions:

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

Issued on this 7th day of September, 2012

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