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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de sions de longue durée**

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**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 |
|---|---|---|---|
| May 10, 2016 | 2016_293554_0005 | 019724-15 | Complaint |

**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 LAKEFIELD
19 FRASER STREET P. O. BOX 910 LAKEFIELD ON K0L 2H0

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

KELLY BURNS (554)

## 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): March 21-23, and March 29, 2016, as well as off-site on March 24, 2016**

**This inspection captured intakes for Complaints, as well as Critical Incident Reports. Intakes reviewed and inspected upon included: #019724-15, #031367-15, #032093-15, #000368-16, #000801-16 and #006349-16.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aide, Housekeeping Aide, Recreational Aide, Behaviour Support**

**Personal Support Worker, and Residents.**

**During the course of this inspection, the inspector toured the home, reviewed clinical health records (both of active and deceased residents), observed resident to resident interactions, observed staff to resident interactions, reviewed home specific policies relating to, Resident Abuse-Staff to Resident, Resident Abuse by Persons Other Than Staff, Falls Prevention and Management Program, Pain Management, Responsive Behaviours, Complaints and Change of Shift Report.**

**Summary of the intakes reviewed and inspected upon include:**

**1) #019724-15 – related to two separate Complaints, the complaints were regarding resident to resident abuse, management of responsive behaviours, specific to resident #001. A Critical Incident Report was inspected during review of this intake, specific to resident #001.**

**2) #031367-15 – related to a Critical Incident Report, specific to an incident, which causes injury to a resident, for which the resident is taken to the hospital and which results in a significant change in resident's health status, specific to resident #003.**

**3) #032093-15 - related to Critical Incident Report, specific to resident to resident abuse, involving resident #019 and resident #020.**

**4) #000368-16 – related to a Critical Incident Report, specific to staff to resident abuse, specific to resident #007.**

**5) #000801-16 – related to two separate Complaints, the complaints were regarding resident to resident abuse, management of responsive behaviours, specific to resident #001. This intake also included three Critical Incident Reports, all relating to resident to resident physical abuse, involving resident #001.**

**6) #006349-16 – related to Critical Incident Report, specific to resident to resident abuse, involving resident #009 and resident #021.**

**NOTE: Evidence relating to areas of non-compliance in this inspection, specifically LTCHA, 2007, s. 6 (8) and O. Reg. 79/10, s. 53 (4) (c), can be found under Inspection #2016_328571_0009 which was inspected concurrently with this inspection.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Pain**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Responsive Behaviours**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (b), by not ensuring that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Related to Resident #008:

Progress notes, for resident #008, were reviewed for a period of approximately one month. Progress notes reviewed provide details of three incidents in which resident #008 exhibited responsive behaviours towards co-residents. In one of the three incidents, resident #008 exhibited a responsive behaviour towards resident #001, resulting in the resident #001 sustaining injury as a result of the said incident.

A review of the plan of care, for resident #008, fails to provide documented evidence that strategies have been developed to respond to incidents in which resident #008 is exhibiting specific responsive behaviours towards resident #001 and or others.

Registered Nurse #012, as well as the Director of Care indicated that the plan of care for each resident demonstrating a responsive behaviour are to include interventions specific to the responsive behaviour the resident is exhibiting. [s. 53. (4) (b)]

2. The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (c), by not ensuring that actions taken to meet the needs of the resident with responsive behaviours include, assessment, reassessment, interventions and the documentation of the resident's responses to the interventions.

Related to Intake #019724-15 and #000801-16, for Resident #001:

The Administrator, and or the Director of Care, have submitted four Critical Incident Reports (CIR) specific to four separate incidents of resident to resident physical abuse involving resident #001 and other residents. In all of the critical incident reports submitted, resident #001 has been said to be the aggressor.

The Ministry of Health and Long-Term Care, has received four complaints from the public with regards to the management of resident #001's responsive behaviour and concerns specific to the safety of others residing in the long-term care home.

The Administrator indicated upon inspector's arrival that the staffing assignment for resident #001 has been adjusted during certain periods of the day and or evening shifts, since a said date, and following an incident of resident to resident physical abuse. Administrator indicated the adjusted staffing hours have decreased since being initiated and are currently during specified hours only.

According to the clinical health record, Resident #001 has a history that includes cognitive impairment. Resident #001 is ambulatory, but is dependent on staff for all other activities of daily living. Resident #001 has a long standing history of exhibiting responsive behaviours.

Personal Support Workers, Registered Nursing Staff, the Director of Care, and the Administrator, all indicated resident #001 exhibits responsive behaviours and that such have been escalating, and are directed towards both residents and staff.

During a clinical health record review, a progress note written by a representative of a community support program, as well as interviews with Registered Nurse #012, #015, and the Director of Care, indicated resident #001's exhibited responsive behaviours are triggered by specific situations.

Progress notes, for resident #001, were reviewed for two identified time periods. The review provides detailed documentation of numerous responsive behaviours exhibited by resident #001, included in the exhibited behaviours, are responsive behaviours directed towards other residents and staff.

Progress notes reviewed, specific to Resident #001's responsive behaviours failed to

consistently provide documentation of the interventions (actions) taken by staff and documentation of the resident's responses to the said interventions.

Personal Support Workers and Registered Nursing Staff interviewed indicated that planned interventions were rarely effective. Nursing staff indicated that it was often difficult to divert Resident #001 when he/she exhibited a responsive behaviour, specifically when said responsive behaviours were escalating.

On a specific date, resident #001 was admitted to an acute care facility.

On a said date, resident #001 returned to the long-term care home. Registered Nurse #012 indicated he/she had updated the plan of care for resident #001, following resident's return from the acute care facility to the long-term care home, adding, that resident #001 requires a nightlight in the bathroom, bright signage has been placed to help resident locate the bathroom when he/she awakens, and has asked the dietary department to ensure something is available should resident #001 awaken a specific hours. The discharge summary from the acute care facility, to address identified responsive behaviours and suggested interventions, was shared with staff and then placed into resident #001's health record.

Progress notes reviewed, specifically for the period of approximately five months, provide documentation detailing sixty-three incidents where resident #001 was exhibiting responsive behaviours which were disruptive to other resident's residing within the resident home area, or incidents posing risk or actual harm to residents and or others.

During dates of this inspection, resident #001 was witnessed exhibiting specific responsive behaviours. Two residents in the dining room were heard telling resident #001 to be quiet on more than one occasion, which in turn upset resident #001, causing verbal exchanges amongst resident #001 and other residents.

Other observations during this inspection, identified that the assigned staffing adjustment, for resident #001, was observed on several occasions not to be in attendance with resident #001.

Progress notes reviewed, for the above period, provide documentation that interventions, non-pharmacological and pharmacological, were ineffective or short lived and that resident #001 continued to exhibit the said responsive behaviours. The progress notes in which staff indicated interventions were ineffective, fail to provide documented evidence

that registered nursing staff took further action to reduce or eliminate the responsive behaviours of resident #001, including contacting the attending or on-call physician, on the said dates.

The licensee further failed to ensure that planned interventions, specifically the assigned staffing adjustments for resident #001 were inconsistently implemented.

Personal Support Worker #014, Registered Practical Nurse #017, Registered Nurse #012 and #015, as well as the Director of Care, all indicated that resident #001 continues to exhibit escalating and unpredictable responsive behaviours, which continue to pose risk of harm to other residents by resident #001, as well risk of harm of resident #001 by other residents. [s. 53. (4) (c)]

3. Related to intake #006349-16, for Resident #009:

A Critical Incident Report was submitted for an incident occurring on a specified date, in which resident #009 exhibited responsive behaviours causing an injury to resident #021.

A review of the clinical records for resident #009 and #021 indicated the following:
- Resident #009 has a history that includes cognition impairment. Resident #009 exhibits identified responsive behaviours, some of which are directed towards other residents and staff.
- Resident #021 has a history that includes cognition impairment. Resident #21 exhibits responsive behaviours, some of which are directed towards other residents, specifically resident #009.

The progress notes, for resident #009 indicate that during an identified period of time, resident #009 demonstrated specific responsive behaviours over a thirteen day period.

A review of the plan of care for resident #009 indicated several interventions for responsive behaviour, including pharmacological interventions were in place. Identified interventions were also in place in the plan of care for resident #021.

Personal Support Workers #100, #101 and #102, all indicated that if resident #009 was demonstrating a responsive behaviour, they were to redirect the resident.

The Administrator indicated in an interview that the staffing compliment on the unit where resident #009 and resident #021 resided was increased by one personal support worker

on specified dates and times.

In conclusion, resident #021 continued to be at risk of abuse by resident #009 due to resident #009's continued responsive behaviours, even after resident #021 was injured by resident #009 on an identified date. Furthermore, other residents continue to be at risk of potential harm due to resident #009's exhibited responsive behaviour, despite interventions already in place.

Therefore, the licensee failed to ensure that the responsive behaviour of resident #009 was reassessed and interventions put in place to prevent resident #009 from exhibiting responsive behaviours that could potentially harm other residents. (571)

Note: This evidence of non-compliance was found during inspection #2016_328571_0009 which was inspected concurrently with this inspection. [s. 53. (4) (c)]

***Additional Required Actions:***

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

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

**Specifically failed to comply with the following:**

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

**s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007, s. 6 (1), by not ensuring there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident, specific to safe-guarding of resident #002.

Related to Intake #019724-15, for Resident #002:

Resident #002 has a history hat includes cognitive impairment; resident requires extensive assistance with activities of daily living. Resident #002 exhibits specific responsive behaviours.

Resident #002's progress notes were reviewed for a period of five months and provide detailed documentation of nine negative interactions between resident #002 and resident #001. The documentation provides evidence that resident #002 was negatively impacted by interactions with resident #001, causing resident #002 to exhibit said responsive behaviours. During one of the nine interactions, resident #002 sustained injury as a result

of resident #001's actions.

The plan of care, was reviewed for the above identified time period, and fails to provide documented evidence as to the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident, specific to procedures and or interventions to be taken to safe-guard resident #002 from resident #001.

Registered Nurse #012 indicated it would be an expectation that the written plan of care for each resident is individualized, documenting not only the planned care, goals of care, as well as clear directions to staff who provide direct care to the resident. [s. 6. (1)]

2. The licensee failed to shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Related to Intake # 032093-15:

Critical Incident Report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, for resident to resident sexual abuse. Resident #020 was witnessed exhibiting a said responsive behaviour towards resident #019 while he/she slept in a chair in a lounge.

Resident #020 and #019, both have a history of cognition impairment and reside on the same resident home area.

A review of the progress notes indicated that on a specific date, resident #020 was observed by a personal support worker exhibiting a said responsive behaviour towards resident #019, while he/she was sleeping in a lounge chair.

The current plan of care for resident #020 indicates that the resident has a potential to exhibit sexually responsive behaviours with staff and other residents. According to the plan of care, resident #020 is to be on heightened monitoring.

The current plan of care for resident #019 indicates that he/she is not to be left unsupervised in common areas.

During an interview the Director of Care, indicated that resident #020 has a history of

exhibiting said responsive behaviour directed towards other residents. Interventions include staff are to take resident #019 to his/her room, if he/she is observed sleeping in the lounge; heightened monitoring for resident #020; and staff are to walk resident #020 to and from the dining room.

Personal Support Workers #014, #104, #106, and Registered Practical Nurse #105, all indicated being unaware of specific exhibited responsive behaviours of resident #020, and or specific interventions in place for resident #019 and or resident #020.

Therefore, the licensee failed to ensure that staff were aware of the current plan of care for resident #020 and #019. (571)

Note: This evidence of non-compliance was found during inspection #2016_328571_0009 which was inspected concurrently with this inspection. [s. 6. (8)]

3. The licensee failed to comply with LTCHA, 2007, s. 6 (11) (b), by not ensuring the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, and that different approaches have been considered in the revision of the plan of care, specific to pain control and management.

Related to Intake #000801-16, for Resident #001:

Resident #001 has a history that includes cognitive impairment, and chronic discomfort. Resident #001 has a long standing history of responsive behaviours, of which a trigger to such behaviours has been linked to resident #001 experiencing discomfort.

A community support program's notes, indicate resident #001 presents with many valid somatic complaints. Ensuring comfort for resident #001, is important and there is evidence to support that ensuring comfort for a resident can reduce responsive behaviours.

The plan of care, was reviewed for resident #001 and identifies that resident frequently expresses somatic complaints, of such include discomfort; interventions listed include:

- Monitor resident for signs and symptoms of discomfort;
- Provide soothing visits and use distraction techniques, such as massage, gentle ROM, music etc;
- Speak with restorative care/PT/OT for possible non pharmacological methods for

addressing resident's discomfort;
- Moist heat therapy daily to aid with comfort;
- Utilize the pain flow record to evaluate the discomfort and report ineffectiveness to physician immediately;
- Offer a warm flannel for comfort;
- If awakens and if unable to resettle, consider discomfort and have registered nursing staff provide PRN (as needed) analgesia. (Note: PRN analgesic was discontinued on or about a specific date)

Physician's Orders currently in place for pain control and management include:
- routine analgesic four times daily by mouth;
- there is no current PRN (as needed) analgesic ordered for this resident.

The clinical health record, for resident #001, was reviewed for a period of approximately three months. Progress notes, during this period, provide documented details of resident #001 exhibiting responsive behaviours, while at the same time voicing discomfort. Progress notes, written by registered nursing staff, indicate that interventions which include routine analgesic have been ineffective, and that resident #001 continues to be unsettled and or to voice discomfort.

Personal Support Workers #013, and #014, Registered Practical Nurse #017 and Registered Nurse #012 and 015, all indicated resident #001 frequently complains of discomfort; all interviewed indicated that discomfort is a contributing factor to resident #001's exhibited responsive behaviours.

Registered Nurse #012 and #015, both indicated that resident #001's complaints of discomfort have been addressed with resident's Attending Physician during scheduled visits to the home without resolve.

The plan of care fails to provide evidence that the Attending or On Call Physician has been contacted during times when both non-pharmacological and pharmacological interventions, for discomfort have been said to be ineffective.

Registered Nurse #012, as well as the Director of Care, both indicated it would be an expectation that a physician would be contacted if interventions for pain management for a resident was not effective. [s. 6. (11) (b)]

***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 there is a monitoring process in place, ensuring the written plan of care for each resident that sets out, the planned care for the resident, the goals the care is intended to achieve, and clear directions to staff and others who provide direct care to the residents; that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it; and to ensure the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007, s. 20 (1), by not ensuring the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The home's policy, Resident Abuse By Persons Other Than Staff (#OPER-02-02-04) indicates that there is a zero tolerance of abuse towards a resident.

The policy, Resident Abuse By Persons Other Than Staff, directs that upon notification of suspected or witnessed abuse, the Administrator, Director of Care or designate will assess the resident and confirm that the resident is safe; to immediately notify the following if the resident experiences abuse that resulted in physical injury, pain or distress, the resident's medical practitioner and request that the resident be assessed as soon as possible.

Related to Intake #000801-16:

The Administrator, of the long-term care home, submitted a Critical Incident Report on an identified date, specific to an incident of resident to resident physical abuse.

The clinical health record for residents #001 and #004 were reviewed, specific to the incident; details of this incident are as follows:

- Resident #001 was witnessed exhibiting a said responsive behaviour directed towards resident #004; staff had to physically intervene and separate the two residents. Following the incident, Resident #004 indicated being upset and complained of discomfort. Registered Nurse #015 assessed resident #004, and documented that resident #004 had sustained injury as a result of the resident to resident abuse incident.

The home's policy was not complied with as evidenced by the following:

- The physician for resident #004 was not informed of the resident to resident abuse incident until two and a half days later, despite documentation in the progress notes, that resident #004 had sustained an injury and continued to voice discomfort.

The Director of Care indicated that staff are to be aware of and follow the home's policies and procedures. [s. 20. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a monitoring process in place, ensuring the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations**
**Every licensee of a long-term care home shall ensure that,**
**(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and**
**(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.**

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg. 79/10, s. 55 (b), by not ensuring direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

The home's policy, Change of Shift Report (#0 NURS-3-01-02) directs that change of shift report will be given by the nurse in charge to all staff on oncoming shift.

Related intake #019724-15 and #000801-16, for Resident #001:

Resident #001 has a history that includes cognition impairment; resident has a history of exhibiting specific responsive behaviours directed towards both residents and staff.

According to the Administrator, staffing adjustments have been made for resident #001, during the specific hours.

Registered Nurse (RN) #012 and #015, as well as the Administrator, all, indicated resident #001's responsive behaviours have been escalating, and that resident #001 has had altercations with co-residents.

During dates of this inspection, the following was observed:

- March 22, 2016, at 08:31 hours, Personal Support Worker (PSW #011) was observed sitting at the dining room table with resident #001. Personal Support Worker #011 indicated he/she was unaware of the care needs, including, resident's exhibited responsive behaviours or interventions in place to manage or eliminate the said responsive behaviours of resident #001. Personal Support Worker #011 that he/she works on another resident home area and has not worked with resident #001 for months.

- March 22, 2016, at 11:41 hours, Personal Support Worker (PSW #013) was assigned to care for resident #001. Personal Support Worker #013 indicated not being aware of any specific responsive behaviours exhibited by the resident nor any strategies in place or interventions to be implemented should resident #001 exhibit identified responsive behaviours. Personal Support Worker #013 indicated that no report, specific to resident #001 had been communicated to him/her at the beginning of the scheduled shift.

- March 29, 2016, at 08:23 hours, Personal Support Worker #016 indicated starting his/her assigned shift at an identified  hour, and had been assigned to care for resident #001. Personal Support Worker #016 indicated he/she was not aware of any care strategies in place or aware of interventions which are to be implemented should resident #001 exhibit said responsive behaviours. Personal Support Worker #016 indicated he/she had not received any report at the beginning of his/her assigned shift, and had heard through co-workers, on another date, that resident #001 has a history of exhibiting a specific responsive behaviour towards residents and others.

Registered Nurse #012 indicated that all personal support workers, no matter what time the staff arrives on shift, should be receiving report from the Registered Practical Nurse assigned to oversee that specific resident home area.

Director of Care indicated that normally the registered nursing staff would read the twenty-four hour report to all oncoming staff, but further indicated if registered nursing

staff were not available or busy, then personal support workers need to take the initiative and read the twenty-four hour report themselves, prior to beginning their duties. Director of Care acknowledged that it would be an expectation that staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring. [s. 55. (b)]

***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 there is a monitoring process in place, ensuring direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others, to be implemented voluntarily.***

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**Issued on this 11th day of May, 2016**

**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

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de sions de longue durée**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | KELLY BURNS (554) |
| **Inspection No. / No de l'inspection :** | 2016_293554_0005 |
| **Log No. / Registre no:** | 019724-15 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | May 10, 2016 |
| **Licensee / Titulaire de permis :** | EXTENDICARE (CANADA) INC.<br>3000 STEELES AVENUE EAST, SUITE 700,<br>MARKHAM, ON, L3R-9W2 |
| **LTC Home / Foyer de SLD :** | EXTENDICARE LAKEFIELD<br>19 FRASER STREET, P. O. BOX 910, LAKEFIELD, ON, K0L-2H0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Dawn Baldwin |

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 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 must prepare, submit and implement a plan for achieving compliance to ensure that strategies are developed and implemented to respond to responsive behaviours exhibited by residents; and to ensure that actions taken to respond to the needs of residents, including assessments, reassessments, interventions and that the resident's response to the interventions are documented.

The plan must include:
- how and when the licensee will seek appropriate support if implemented strategies provided prove to be ineffective;
- processes for monitoring that the planned interventions for responding to responsive behaviours are implemented by staff and the effect of the intervention is documented;
- a process for reassessment, monitoring and re-evaluation of best care strategies.

The correction action plan must be submitted in writing to the Attention of: Kelly Burns, LTC Homes Inspector-Nursing, and faxed to (613) 569-9670, on or before May 17, 2016.

**Grounds / Motifs :**

1. The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (b), by not

ensuring that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Related to Resident #008:

Progress notes, for resident #008, were reviewed for a period of approximately one month. Progress notes reviewed provide details of three incidents in which resident #008 exhibited responsive behaviours towards co-residents. In one of the three incidents, resident #008 exhibited a responsive behaviour towards resident #001, resulting in the resident #001 sustaining injury as a result of the said incident.

A review of the plan of care, for resident #008, fails to provide documented evidence that strategies have been developed to respond to incidents in which resident #008 is exhibiting specific responsive behaviours towards resident #001 and or others.

Registered Nurse #012, as well as the Director of Care indicated that the plan of care for each resident demonstrating a responsive behaviour are to include interventions specific to the responsive behaviour the resident is exhibiting. (554)

2. The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (c), by not ensuring that actions taken to meet the needs of the resident with responsive behaviours include, assessment, reassessment, interventions and the documentation of the resident's responses to the interventions.

Related to intake #006349-16, for Resident #009:

A Critical Incident Report was submitted for an incident occurring on a specified date, in which resident #009 exhibited responsive behaviours causing an injury to resident #021.

A review of the clinical records for resident #009 and #021 indicated the following:
- Resident #009 has a history that includes cognition impairment. Resident #009 exhibits identified responsive behaviours, some of which are directed towards other residents and staff.
- Resident #021 has a history that includes cognition impairment. Resident #21

exhibits responsive behaviours, some of which are directed towards other residents, specifically resident #009.

The progress notes, for resident #009 indicate that during an identified period of time, resident #009 demonstrated specific responsive behaviours over a thirteen day period.

A review of the plan of care for resident #009 indicated several interventions for responsive behaviour, including pharmacological interventions were in place. Identified interventions were also in place in the plan of care for resident #021.

Personal Support Workers #100, #101 and #102, all indicated that if resident #009 was demonstrating a responsive behaviour, they were to redirect the resident.

The Administrator indicated in an interview that the staffing compliment on the unit where resident #009 and resident #021 resided was increased by one personal support worker on specified dates and times.

In conclusion, resident #021 continued to be at risk of abuse by resident #009 due to resident #009's continued responsive behaviours, even after resident #021 was injured by resident #009 on an identified date. Furthermore, other residents continue to be at risk of potential harm due to resident #009's exhibited responsive behaviour, despite interventions already in place.

Therefore, the licensee failed to ensure that the responsive behaviour of resident #009 was reassessed and interventions put in place to prevent resident #009 from exhibiting responsive behaviours that could potentially harm other residents. (571)

Note: This evidence of non-compliance was found during inspection #2016_328571_0009 which was inspected concurrently with this inspection. (554)

3. Related to Intake #019724-15 and #000801-16, for Resident #001:

The Administrator, and or the Director of Care, have submitted four Critical Incident Reports (CIR) specific to four separate incidents of resident to resident physical abuse involving resident #001 and other residents. In all of the critical

incident reports submitted, resident #001 has been said to be the aggressor.

The Ministry of Health and Long-Term Care, has received four complaints from the public with regards to the management of resident #001's responsive behaviour and concerns specific to the safety of others residing in the long-term care home.

The Administrator indicated upon inspector's arrival that the staffing assignment for resident #001 has been adjusted during certain periods of the day and or evening shifts, since a said date, and following an incident of resident to resident physical abuse. Administrator indicated the adjusted staffing hours have decreased since being initiated and are currently during specified hours only.

According to the clinical health record, Resident #001 has a history that includes cognitive impairment. Resident #001 is ambulatory, but is dependent on staff for all other activities of daily living. Resident #001 has a long standing history of exhibiting responsive behaviours.

Personal Support Workers, Registered Nursing Staff, the Director of Care, and the Administrator, all indicated resident #001 exhibits responsive behaviours and that such have been escalating, and are directed towards both residents and staff.

During a clinical health record review, a progress note written by a representative of a community support program, as well as interviews with Registered Nurse #012, #015, and the Director of Care, indicated resident #001's exhibited responsive behaviours are triggered by specific situations.

Progress notes, for resident #001, were reviewed for two identified time periods. The review provides detailed documentation of numerous responsive behaviours exhibited by resident #001, included in the exhibited behaviours, are responsive behaviours directed towards other residents and staff.

Progress notes reviewed, specific to Resident #001's responsive behaviours failed to consistently provide documentation of the interventions (actions) taken by staff and documentation of the resident's responses to the said interventions.

Personal Support Workers and Registered Nursing Staff interviewed indicated that planned interventions were rarely effective. Nursing staff indicated that it

was often difficult to divert Resident #001 when he/she exhibited a responsive behaviour, specifically when said responsive behaviours were escalating.

On a specific date, resident #001 was admitted to an acute care facility.

On a said date, resident #001 returned to the long-term care home. Registered Nurse #012 indicated he/she had updated the plan of care for resident #001, following resident's return from the acute care facility to the long-term care home, adding, that resident #001 requires a nightlight in the bathroom, bright signage has been placed to help resident locate the bathroom when he/she awakens, and has asked the dietary department to ensure something is available should resident #001 awaken a specific hours. The discharge summary from the acute care facility, to address identified responsive behaviours and suggested interventions, was shared with staff and then placed into resident #001's health record.

Progress notes reviewed, specifically for the period of approximately five months, provide documentation detailing sixty-three incidents where resident #001 was exhibiting responsive behaviours which were disruptive to other resident's residing within the resident home area, or incidents posing risk or actual harm to residents and or others.

During dates of this inspection, resident #001 was witnessed exhibiting specific responsive behaviours. Two residents in the dining room were heard telling resident #001 to be quiet on more than one occasion, which in turn upset resident #001, causing verbal exchanges amongst resident #001 and other residents.

Other observations during this inspection, identified that the assigned staffing adjustment, for resident #001, was observed on several occasions not to be in attendance with resident #001.

Progress notes reviewed, for the above period, provide documentation that interventions, non-pharmacological and pharmacological, were ineffective or short lived and that resident #001 continued to exhibit the said responsive behaviours. The progress notes in which staff indicated interventions were ineffective, fail to provide documented evidence that registered nursing staff took further action to reduce or eliminate the responsive behaviours of resident #001, including contacting the attending or on-call physician, on the said dates.

The licensee further failed to ensure that planned interventions, specifically the assigned staffing adjustments for resident #001 were inconsistently implemented.

Personal Support Worker #014, Registered Practical Nurse #017, Registered Nurse #012 and #015, as well as the Director of Care, all indicated that resident #001 continues to exhibit escalating and unpredictable responsive behaviours, which continue to pose risk of harm to other residents by resident #001, as well risk of harm of resident #001 by other residents. (554)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 17, 2016

## 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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de sions de longue durée
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
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

**Issued on this 10th day of May, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Kelly Burns

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