Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
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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
Sep 5, 6, 7, 2012	2012_043157_0029	Critical Incident

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North, OSHAWA, ON, L1J-4L1

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

EXTENDICARE PETERBOROUGH
80 ALEXANDER AVENUE, PETERBOROUGH, ON, K9J-6B4

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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with The home's acting Administrator, Director of Care, one Registered Nurse, the home's Best Practice Coordinator, Psychogeriatric Nurse Specialist.

During the course of the inspection, the inspector(s) reviewed the clinical health records of residents #001, #002, #003; observed resident #002, resident #003; reviewed the home's policies related to Abuse and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification 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. 19. Duty to protect

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The following findings demonstrate that the licensee failed to protect two identified residents by failing to implement interventions to mitigate the risks associated with the known behaviours of another resident.

Resident #001 was admitted to the home. The resident's clinical health record indicates the resident demonstrated inappropriate behaviours.

A care planning focus on the written plan of care for resident #001 identifies inappropriate behaviours as a focus and provides direction for non-specific interventions.

Progress notes for resident #003 and a Critical Incident Report indicate that resident #001 was observed to assault resident #003. The resident who was assaulted experienced trauma and pain.
- Hourly checks (Focused Behavioural Flow Sheet") of resident #001 were completed for seven days . There is no evidence of a plan to monitor the resident's behaviour or when the decision was made that monitoring was no longer required.
- There is no behavioural monitoring identified for resident #001 for identified periods on 4 dates during the monitoring period.
- Monitoring outcomes for resident #001 indicate that inappropriate behaviour was identified on 5 occasions. There is no evidence of action taken in response to these incidents.
- Following the discontinuation of documented hourly monitoring of resident #001, there was no direction to staff and no evidence of interventions in place to ensure the protection and safety of residents.
- the written plan of care for resident #001 does not provide current direction for interventions related to the recent incident.

Nine weeks following this incident, progress notes for resident #002 and a Critical Incident Report indicate that resident #002 was assaulted by resident #001.
- following the incident, progress notes indicate that resident #002 suffered fear and trauma and physical discomfort.
- Every 5 minute checks of resident #001(Focused Behavioural Flow Sheet) were completed for one day
- the written plan of care for resident #001 does not provide direction for interventions related to the recent incident.
[s.19.(1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The written plan of care for resident #001 does not provide clear direction to staff related to incidents involving residents #002 and #003.
- The plan of care does not provide clear direction to staff for interventions to protect other residents.
- The plan of care does not provide clear direction to staff related to behavioural triggers or mechanisms to be used to monitor behaviours. [s.6.(1)(c)] (Log #002816-11, #000493-12)
2. - An intervention identified in the plan of care for resident #001 related to monitoring behaviours was not complied with.
- An intervention in the plan of care for resident #001 directs the observation of specific data related to behaviours. There is no evidence that there was observation for this data. [s.6.(7)] (Log #0002816-11, #00493-12)
3. The home's policy, Responsive Behaviours, Policy Number 09-05-01, dated September 2012 directs the following: The care plan is to contain information related to each behaviour observed and should include at a minimum:
- triggers to the behaviour
- ways to complete a task or ADL that minimize the liklihood of the behaviour appearing
- describe in detail what the behaviour actually is
- interventions to deal with the behaviour
- what to do if the interventions are not effective and/or if the behaviour escalates
- fluctuations in the resident behaviour including times when the behaviour is more prevalent and times when the behaviour is non-existent.
The home failed to comply with the established policy as none of the above noted information is provided on the care plan for resident #001.[s.6.(1)(c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care provides clear direction to staff and other who provide direct care to the resident related to interventions for resident responsive behaviours and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. There is no evidence that there were actions taken to assess and respond to the needs of resident #001 who frequently demonstrated inappropriate behaviours. There is no evidence of assessments, reassessments, interventions or evaluation of resident responses to interventions.
The home's policy "Responsive Behaviours, Policy #09-05-01, Dated September 2012" directs the following:
"If using the MDS 2.0 assessment tool, upon completion of the tool, the Aggressive Behaviour Scale (ABS) score is to be reviewed. If the ABS score is greater than 2, a further in-depth assessment of the resident's behaviour will be undertaken using any one of the assessment tools in #3 above." The tools referenced are the Dementia Observation Scale, Cohen Mansfield Agitation Investory, Responsive Behavior Record, Tool used by the local psychogeriatric outreach/support program.
The ABS score for resident #001 was greater than 2. There is no evidence that a further in-depth assessment of the resident's behaviour was undertaken.[s.53.(4)(c)]
2. The home's policy "Responsive Behaviours", Policy #09-05-01, Dated September 2010, directs the following:
"If the behaviour poses a risk to the residents or others, the care plan is to outline the frequency of resident observation for safety as well as the immediate action to be taken if there is an imminent risk to others."
The home failed to comply with the identified policy as the plan of care for an identified resident did not outline the frequency of observation of resident #001 for safety when a risk to other residents was identified.[s.53.(4)(b)] (Log #002816-11, #000493-12)
3. Each resident displaying responsive behaviours will have this behaviour observed and assessed. A resident focused care plan will be developed and maintained that includes:
- Triggers to the behaviour
- Preventative measures to minimize the risk of the behaviour developing or escalating
- Resident specific interventions to address behaviours
- Strategies staff are to follow if the interventions are not effective
The home failed to comply with this policy as a focused plan of care is not provided which includes triggers for resident #001's behaviours. [s.53.(4)(a)] (Log #002816-11, #000493-12)
4. There is no evidence that strategies were developed and implemented to respond to behaviours demonstrated by resident #001 or related to the risk to residents #002 and #003. [s.53.(4)(b)] (Log #002816-11, #000493-12)
5. There is no indication that resident #001 was assessed to determine and identify responsive behavioural triggers. [s.53.(4)(a)] (Log #002816-11, #000493-12)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each for each resident demonstrating responsive behaviours, behavioural triggers are identified, strategies are developed to respond to behaviours and actions are taken to respond to the needs of the resident, to be implemented voluntarily.

Issued on this 7th day of September, 2012

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

Lynn Duchesne
for Pat Powers.

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) :	PATRICIA POWERS (157)
Inspection No. / No de l'inspection :	2012_043157_0029
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Sep 5, 6, 7, 2012
Licensee / Titulaire de permis :	EXTENDICARE CENTRAL ONTARIO INC 82 Park Road North, OSHAWA, ON, L1J-4L1
LTC Home / Foyer de SLD :	EXTENDICARE PETERBOROUGH 80 ALEXANDER AVENUE, PETERBOROUGH, ON, K9J-6B4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DAWN BALDWIN

To EXTENDICARE CENTRAL ONTARIO 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 :

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

Order / Ordre :

The licensee must prepare, implement and submit a plan to ensure that residents are protected from abuse by anyone by ensuring that residents demonstrating behaviours which pose a risk to others are assessed and that interventions to protect other residents from harm are incorporated into the resident plan of care and provide clear direction to staff.
Written plan is to be submitted to MOHLTC, Attention Pat Powers, fax (613)569-9670 by September 28, 2012.

Grounds / Motifs :

1. 1. The following findings demonstrate that the licensee failed to protect two identified residents by failing to implement interventions to mitigate the risks associated with the known behaviours of another resident.

Resident #001 was admitted to the home. The resident's clinical health record indicates the resident demonstrated inappropriate behaviours.

A care planning focus on the written plan of care for resident #001 identifies inappropriate behaviours as a focus and provides direction for non-specific interventions.

Progress notes for resident #003 and a Critical Incident Report indicate that resident #001 was observed to assault resident #003. The resident who was assaulted experienced trauma and pain.
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- There is no behavioural monitoring identified for resident #001 for identified periods on 4 dates during the monitoring period.
- Monitoring outcomes for resident #001 indicate that inappropriate behaviour was identified on 5 occasions. There is no evidence of action taken in response to these incidents.
- Following the discontinuation of documented hourly monitoring of resident #001, there was no direction to staff and no evidence of interventions in place to ensure the protection and safety of residents.
- the written plan of care for resident #001 does not provide current direction for interventions related to the recent incident.

Nine weeks following this incident, progress notes for resident #002 and a Critical Incident Report indicate that resident #002 was assaulted by resident #001.
- following the incident, progress notes indicate that resident #002 suffered fear and trauma and physical discomfort.
- Every 5 minute checks of resident #001(Focused Behavioural Flow Sheet) were completed for one day
- the written plan of care for resident #001 does not provide direction for interventions related to the recent incident. [s.19.(1)] (157)

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 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

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

and the

Director

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.

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

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 : Lynn Dochuno for

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

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