Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

# Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 3, 2014 | 2014_376594_0011 | S-000270-14 | 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 TIMMINS
62 St-Jean Avenue, TIMMINS, ON, P4R-0A6

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

MONIKA GRAY (594)

## 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): August 18-21, 2014**

**This inspection was conducted concurrently with a Critical Incident System inspection.**

**During the course of the inspection, the inspector(s) spoke with Residents, Health Care Aides (HCAs), Personal Support Worker (PSW), Registered Practical Nurses (RPNs), Registered Nurse (RN), Housekeeping staff, Clinical Coordinator, Resident Assessment Instrument (RAI) Coordinator, Support Services Manager, Behavioural Supports Ontario (BSO) Clinician, Director of Care (DOC) and the Administrator.**

**During the course of the inspection, the inspector(s) conducted daily walk through of the resident care areas, observed staff to resident interactions, reviewed resident health care records and reviewed some policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Laundry**
**Reporting and Complaints**
**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

| 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 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #001. Record review of resident #001’s plan of care specific to dressing identified:
Focus: Potential difficulty with Dressing
Intervention: independent with set up assistance – staff lay out clothes

The inspector interviewed staff #S-114 who stated staff will lay out clothing in the morning and were given direction by the Support Services Manager to have resident #001’s closet locked. Interview with staff #S-115 stated that staff will unlock the closet doors for resident #001 to pick out their outfit for the day and re lock immediately after. When inspector asked staff #S-115 where they find direction specific to resident care, they stated that staff let each other know about a resident’s care, if they are unsure. Interview with resident #001 verified they pick out their outfit in the morning. Interview with the DOC verified the plan of care does not set out clear direction to staff and others who provide direct care to resident #001 specific to their closet being locked and staff are to provide resident #001 the right to choose their outfit. [s. 6. (1) (c)]

2. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to resident #002. A critical incident reported to the Director identified that resident #002 was settled to bed with tab monitor on, and a RPN was alerted by resident #002 yelling and was found curled up on the floor beside

their bed. Resident #002 had turned off their tabs monitor and got out of bed resulting in a fracture. The report to the Director further identified resident #002 continuously turns off tab monitor and self transfers.

Review of resident #002's care plan identified the following interventions specific to the focus of potential falls/injury related to toileting/transferring self continuously, removes and turns off tab monitor:
- Remind resident to call for assistance for all transfers and to use wheelchair at all times and not to try and ambulate on own
- Morse fall risk assessment completed: High Risk.
- Apply tab monitor on when resident is in bed or on wheelchair

Interviews with staff #S-109 and DOC identified that the tab monitor has been moved to various locations on the wheelchair and when the resident is in bed staff are to discourage resident #002 from turning tab monitor off.

The care plan fails to set clear directions to staff specifically related to applying the tab monitor in various locations on wheelchair and staff discouraging resident #002 from turning tab monitor off. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective. When Resident #002 was admitted their care plan, specific to falls, listed the following interventions which were resolved on May 09, 2014:
- Check q30 minutes for safety during periods where risk for falls is increased, encourage resident to call staff on call bell
- Identify root causes of falls and work with resident, family and team to develop strategies to address
- Evaluate and supply adaptive/walking equipment or devices, wheelchair. Re-evaluate as needed for continued appropriateness
- Refer to physiotherapist
- Co-ordinate with appropriate staff to ensure a safe environment eg: floor surfaces even, glare-free lighting, bed in low position, personal items within reach

Two additional interventions were listed for resident #002, which remain in effect:
- Remind resident to call for assistance for all transfers and to use wheelchair at all times and not to try and ambulate on their own
- Apply tab monitor on when resident is in bed or on wheelchair

According to a Critical Incident reported to the Director on December 02, 2013, resident #002 had the following history of falls; in 2012 five documented falls and in 2013, eight documented falls.

Upon review of resident #002's health care record, the inspector identified a history of eight documented falls during 2014, up to and including August 20, 2014. Review of Post Fall Assessment Progress note identified "care plan reviewed and no update required" on seven of eight Post Fall Assessment Progress notes, one Post Fall Assessment Progress note did not identify care plan review.

Resident #002's Quarterly reviews, two resident assessment protocol (RAP) state "Resident is at risk for further falls. They have unsteady gait and walks with physio. Their primary mode of locomotion is their wheelchair. They do have a tab monitor while in wheelchair. Will care plan to prevent falls, minimize injury related to falls. No referral required at this time."

Interview with staff #S-107 who stated resident tries to self-transfer. DOC stated many interventions have been tried with resident #002 including health teaching and daily involvement in activities and physiotherapy.

Given that resident #002 has a history of falls during 2012, 2013, and up until August 20, 2014, the licensee has failed to ensure the plan of care is reviewed and revised when care set out in the plan has not been effective. [s. 6. (10) (c)]

***Additional Required Actions:***

***CO # - 001, 003 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 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 has failed to ensure for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the residents' responses to interventions are documented. Inspector reviewed resident #001's progress notes for the period of six months and identified 31 incidents of responsive behaviours.

When resident #001 was admitted to the home a responsive behaviours assessment was completed with no identified concerns. Subsequent to admission, the Lost Clothing Complaint Form and resident #001 progress notes identify family concerns for resident #001's lost clothing. Review of resident #001's progress notes over six months state that on nine occasions resident was witnessed by staff exhibiting responsive behaviours related to their clothes. According to progress notes, resident #001's closet was locked by staff and resident #001 was upset that they were denied access to a key for the lock. Resident #001's responsive behaviours increased and a later progress note identified physician and BSO Clinician to be notified and to use medication as required for anxiety. Progress notes identified resident attempting to exit-seek and resident #001's window screen cut and safety stoppers removed allowing window to fully open.

A review of the home's policy Responsive Behaviours #09-05-01 states each resident will be assessed and observed for indicators of responsive behaviours on admission and quarterly thereafter, at a minimum. Ongoing, all staff is to report, record and investigate all new instances of a behaviour that is not currently addressed in the resident's plan of care. 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; and,
- strategies staff are to follow if the interventions are not effective.

Resident #001's current care plan accessible to direct care staff, specific to behaviours, was reviewed.

The inspector reviewed resident #001's health care record and identified a quarterly MDS assessment which states "resident is at risk to harm them self by being physically aggressive. Will care plan to improve ABS score to 0 and minimize risk. No referral needed at this time. Nursing staff will continue to monitor." Daily Responsive Behaviour Record over seven days identified three incidents of responsive behaviour. One incident resolved by BSO support, other two incidents by redirection.

Interview with the BSO Clinician stated they read daily nursing reports from each unit and will initiate BSO involvement when resident behaviours are out of character or require interventions. BSO Clinician validated awareness of resident #001's escalation in responsive behaviours and verified no further assessments, reassessments or interventions were completed for resident #001.

Despite staff diverting resident #001's responsive behaviour with medication and locking resident's clothes in their closet, the licensee has failed to ensure that other actions were taken to respond to the needs of resident #001 including assessment, reassessments, interventions and referrals related to managing resident #001's ongoing and numerous responsive behaviours. [s. 53. (4) (c)]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service**

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

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,**
**(a) procedures are developed and implemented to ensure that,**
**(i) residents' linens are changed at least once a week and more often as needed,**
**(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,**
**(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and**
**(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the process to report and locate residents' lost clothing and personal items has been implemented related to resident #001, who was missing a personal item on April 13, 2014 and several occurrences of missing clothing.

Resident #001's progress note dated April 13, 2014 documented that a resident stated their personal item was lost, staff searched residents room and unable locate, will continue to monitor and day shift RPN to speak with laundry management and check lost and found. A progress note dated April 16, 2014 states "will continue to look for missing items".

The home's policy Missing Clothing #HKLD-06-03-13 states if a complaint related to missing clothing is received, notify Laundry staff promptly along with the necessary information to conduct a search for clothing in the laundry area and follow the corporate complaint process, search unit for reported missing clothing. The home's Complaint policy #09-04-06 states when a verbal complaint is received, where possible an investigation will be initiated immediately (missing laundry, missing glasses, etc.) and if the investigation cannot be initiated immediately and/or resolution cannot be obtained within 24 hours, the Department Manager will initiate an investigation, including a written record of the investigation and outcome.

Interview with direct care staff #S-107 who stated if a resident identifies missing clothing, staff will ask the resident the description, and when it was last seen. Check with laundry and then go look in the lost and found. If it has not been located it will be

reported to registered staff. Interview with registered staff #S-112 who stated if staff are notified of lost clothing or personal items, registered staff chart in the resident's electronic medical record, leave a note at the nursing station to notify others of missing items and report to RN/DOC. Interview with staff #S-113 who stated if a resident identifies lost clothing, staff to check with laundry and check in lost and found and then report to the Support Services Manager. Interview with staff #S-111 who stated if resident items are lost, staff search for items in the unit care area and expand to other unit care areas if not located, document in resident chart and complete lost item form which is sent to the Nursing coordinator and to inform the resident's family. Interview with staff #S-103 who stated the process is that staff are to check resident's room for clothing/items, PSWs or registered staff will go look in lost and found and then complete lost clothing complaint form, used for both lost clothing and lost items and send to the Support Services Manager.

Interview with the Support Services Manager who told the inspector the process to report and locate resident's lost clothing and personal items is when a lost item is expressed by family or the resident, staff are to look in the resident room and surrounding areas, look in lost and found and then complete a Lost Clothing Form which is sent to the Support Services Manager, however often notice comes on a piece of paper or by word of mouth. The Support Services Manager stated they were not involved with the missing personal item for resident #001. Interview with the DOC who stated the process to report and locate a resident's lost personal item is that staff are to complete a complaint form which is sent to the Support Services Manager who will search for the item. Registered staff are to document on shift report stating the resident item is missing and after 24hrs complete and submit a complaint report. The DOC verified no documentation was received or charting within resident #001's electronic medical record for resident #001's missing ring.

Despite the home having a policy on missing clothing and complaints, the licensee has failed to implement the process related to reporting and locating resident's lost clothing and personal items. [s. 89. (1) (a) (iv)]

***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 the process to report and locate residents' lost clothing and personal items will be implemented, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that the complaint procedure for initiating complaints to the licensee and for how the licensee deals with complaints has been complied with.

Resident #001's progress note dated April 13, 2014 documented that a resident stated their personal item was lost, staff searched residents room and unable to locate, will continue to monitor and day shift RPN to speak with laundry management and check lost and found.  A progress note dated April 16, 2014 stated that a PSW reported to this writer that resident and family members were expressing concerns regarding missing articles of clothing and an expensive personal item that is also missing. PSW reported that they spoke to family members and resident in regards to laundry rotation and that they are currently searching for the missing items, and that when/if they are found they will be promptly returned. Please keep searching for missing items.

The home's Complaint policy #09-04-06 states when a verbal complaint is received, where possible an investigation will be initiated immediately (missing laundry, missing glasses, etc.) and if the investigation cannot be initiated immediately and/or resolution cannot be obtained within 24 hours, the Department Manager will initiate an investigation, including a written record of the investigation and outcome.

The inspector interviewed staff #S-103, #S-111 who stated when a complaint is received from residents or family, staff are to complete the home's complaint form titled Lost Clothing Complaint Form and submit to the Support Services Manager. Interview with the Support Services Manager verified the Lost Clothing Complaint Form is used for both lost clothing complaints and other lost item complaints and a copy of the completed Complaint Form is provided to the DOC. Interview with the DOC validated that no written documentation was received regarding a verbal complaint.

Given a PSW received a verbal complaint from resident #001’s family regarding a missing personal item, identified on April 13, 2014, with no resolution within 24 hours, and no further action was taken, the licensee has failed to ensure the home`s Complaint policy was complied with. [s. 8. (1) (b)]

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**Issued on this 12th day of November, 2014**

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

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) :** | MONIKA GRAY (594) |
| **Inspection No. / No de l'inspection :** | 2014_376594_0011 |
| **Log No. / Registre no:** | S-000270-14 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Oct 3, 2014 |
| **Licensee / Titulaire de permis :** | EXTENDICARE (CANADA) INC.<br>3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2 |
| **LTC Home / Foyer de SLD :** | EXTENDICARE TIMMINS<br>62 St-Jean Avenue, TIMMINS, ON, P4R-0A6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | KELLY TREMBLAY |

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) (a)

**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 ensure the written plan of care for resident #001, sets out clear directions to staff and others who provide direct care to the resident specifically related to resident #001's locked closet and ensuring the resident's right to participate in decision-making is respected regarding their choice of clothing.

The licensee shall also ensure the written plan of care for resident #002 sets out clear directions to staff and others who provide direct care to the resident specific to resident #002's tab monitor.

**Grounds / Motifs :**

1. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to resident #002. A critical incident reported to the Director identified that resident #002 was settled to bed with tab monitor on, and a RPN was alerted by resident #002 yelling and was found curled up on the floor beside their bed. Resident #002 had turned off their tabs monitor and got out of bed resulting in a fracture. The report to the Director further identified resident #002 continuously turns off tab monitor and self transfers.

Review of resident #002's care plan identified the following interventions specific to the focus of potential falls/injury related to toileting/transferring self continuously, removes and turns off tab monitor:
- Remind resident to call for assistance for all transfers and to use wheelchair at

all times and not to try and ambulate on own
- Morse fall risk assessment completed: High Risk.
- Apply tab monitor on when resident is in bed or on wheelchair

Interviews with staff #S-109 and DOC identified that the tab monitor has been moved to various locations on the wheelchair and when the resident is in bed staff are to discourage resident #002 from turning tab monitor off.

The care plan fails to set clear directions to staff specifically related to applying the tab monitor in various locations on the wheelchair and staff discouraging resident #002 from turning tabs monitor off. (594)

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #001. Record review of resident #001's plan of care specific to dressing identified:
Focus: Potential difficulty with Dressing
Intervention: independent with set up assistance – staff lay out clothes

The inspector interviewed staff #S-114 who stated staff will lay out clothing in the morning and were given direction by the Support Services Manager to have resident #001's closet locked. Interview with staff #S-115 stated that staff will unlock the closet doors for resident #001 to pick out their outfit for the day and re lock immediately after. When inspector asked staff #S-115 where they find direction specific to resident care, they stated that staff let each other know about a resident's care, if they are unsure. Interview with resident #001 verified they pick out their outfit in the morning. Interview with the DOC verified the plan of care does not set out clear direction to staff and others who provide direct care to resident #001 specific to their closet being locked and staff are to provide resident #001 the right to choose their outfit. (594)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 27, 2014

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**Order # / Ordre no :** 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**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 shall ensure that actions are taken to respond to the needs of resident #001 demonstrating responsive behaviours including assessments, reassessments and interventions specific to resident #001 and that the resident's response to the interventions are documented.

**Grounds / Motifs :**

1. The licensee has failed to ensure for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the residents' responses to interventions are documented. Inspector reviewed resident #001's progress notes for the period of six months and identified 31 incidents of responsive behaviours.

When resident #001 was admitted to the home a responsive behaviours assessment was completed with no identified concerns. Subsequent to admission, the Lost Clothing Complaint Form and resident #001 progress notes identify family concerns for resident #001's lost clothing. Review of resident #001's progress notes over six months state that on nine occasions resident was witnessed by staff exhibiting responsive behaviours related to their clothing. According to progress notes resident #001's closet was locked by staff and resident #001 was upset that they were denied access to a key for the lock. Resident #001's responsive behaviours increased and a later progress note

identified physician and BSO Clinician to be notified and to use medication as required for anxiety. Progress note identified resident attempting to exit-seek and resident #001's window screen cut and safety stoppers removed allowing window to fully open.

A review of the home's policy Responsive Behaviours #09-05-01 states each resident will be assessed and observed for indicators of responsive behaviours on admission and quarterly thereafter, at a minimum. Ongoing, all staff is to report, record and investigate all new instances of a behaviour that is not currently addressed in the resident's plan of care. 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; and,
- strategies staff are to follow if the interventions are not effective.

Resident #001's current care plan accessible to direct care staff, specific to behaviours was reviewed.

The inspector reviewed resident #001's health care record and identified a quarterly MDS assessment which states "resident is at risk to harm them self by being physically aggressive. Will care plan to improve ABS score to 0 and minimize risk. No referral needed at this time. Nursing staff will continue to monitor." Daily Responsive Behaviour Record identified three incidents of responsive behaviour. One incident resolved by BSO support, other two incidents by redirection.

Interview with the BSO Clinician stated they read daily nursing reports from each unit and will initiate BSO involvement when resident behaviours are out of character or require interventions. BSO Clinician validated awareness of resident #001's escalation in responsive behaviours and verified no further assessments, reassessments or interventions were completed for resident #001.

Despite staff diverting resident #001's responsive behaviour with medication and locking resident's clothes in their closet, the licensee has failed to ensure that other actions were taken to respond to the needs of resident #001 including assessment, reassessments, interventions and referrals related to managing

resident #001's ongoing and numerous responsive behaviours. (594)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 27, 2014

**Order # / Ordre no :** 003

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

**Order / Ordre :**

The licensee shall review and revise resident #002's plan of care to ensure that the resident's care needs and high risk related to ongoing falls is addressed in so far as the care set out in the plan of care has not been effective.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective. When resident #002 was admitted their care plan, specific to falls, listed the following interventions which were resolved on May 09, 2014:
- Check q30 minutes for safety during periods where risk for falls is increased, encourage resident to call staff on call bell
- Identify root causes of falls and work with resident, family and team to develop strategies to address
- Evaluate and supply adaptive/walking equipment or devices, wheelchair. Re-evaluate as needed for continued appropriateness
- Refer to physiotherapist
- Co-ordinate with appropriate staff to ensure a safe environment eg: floor surfaces even, glare-free lighting, bed in low position, personal items within reach

Two additional interventions were listed for resident #002, which remain in effect:

- Remind resident to call for assistance for all transfers and to use wheelchair at all times and not to try and ambulate on their own
- Apply tab monitor on when resident is in bed or on wheelchair

According to a Critical Incident reported to the Director on December 02, 2013, resident #002 had the following history of falls; in 2012 five documented falls and in 2013, eight documented falls.

Upon review of resident #002's health care record, the inspector identified a history of eight documented falls during 2014, up to and including August 20, 2014. Review of Post Fall Assessment Progress note identified “care plan reviewed and no update required” on seven of eight Post Fall Assessment Progress notes, one Post Fall Assessment Progress note did not identify care plan review.

Resident #002's Quarterly reviews, two resident assessment protocol (RAP) state “Resident is at risk for further falls. They have unsteady gait and walks with physio. Their primary mode of locomotion is their wheelchair. They do have a tab monitor while in wheelchair. Will care plan to prevent falls, minimize injury related to falls. No referral required at this time.”

Interview with staff #S-107 who stated resident tries to self-transfer. DOC stated many interventions have been tried with resident #002 including health teaching and daily involvement in activities and physiotherapy.

Given that resident #002 has a history of falls during 2012, 2013, and up until August 20, 2014, the licensee has failed to ensure the plan of care is reviewed and revised when care set out in the plan has not been effective. (594)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 27, 2014

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board  and the Director

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

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

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

**Issued on this 3rd day of October, 2014**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Monika Gray

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