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 soins de longue durée

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 13, 2016	2016_395613_0004	005680-16	Resident Quality Inspection

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 VAN DAELE
39 Van Daele Street Sault Ste Marie ON P6B 4V3

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

LISA MOORE (613), JENNIFER LAURICELLA (542), SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 29 - April 1, 2016 and April 4 - 8, 2016

Additional logs conducted during this Resident Quality Inspection (RQI) include:
a complaint regarding resident to resident abuse,
a complaint regarding the home withholding medical records,
a complaint regarding missing personal care item and care concerns,
a complaint regarding an employee
a complaint of a resident's responsive behaviours,
a critical incident the home submitted related to alleged verbal and physical abuse by a family member to a resident
a critical incident the home submitted related to a personal assistance service device (PASD) used to restrain a resident
a critical incident the home submitted related to alleged resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Support Service Manager, Program Manager, Admission Coordinator, Activity Aide, Maintenance, Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Registered Staff (RNs and RPNs), Personal Support Workers (PSW), family members and residents.

During the course of the Resident Quality Inspection, the Inspectors conducted a daily walk through of the resident home areas and various common areas, made direct observation of the delivery of care and services provided to the residents, observed staff to resident interactions, reviewed resident health care records and various policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the actions taken to meet the needs of resident #027 with responsive behaviours included assessments, reassessments, interventions and documentation of the resident`s responses to the interventions.

Inspector #542 reviewed a complaint submitted to the Director that indicated resident #015 was physically assaulted by resident #027 in December 2015. A Critical Incident (CI) was also submitted to the Director by the home, which identified that resident #027 had exhibited specific responsive behaviours towards resident #015. A staff member intervened and told resident #027 to stop and then resident #027 exhibited different responsive behaviours towards resident #015. Another staff member assisted and resident #027 was removed from their room.

A closed health care record review for resident #027 was completed. The Inspector reviewed the assessments on Point Click Care (PCC) and was unable to determine if resident #027 had been assessed with regards to their responsive behaviors. The Inspector reviewed the admission assessment that was completed by Community Care Access Centre which outlined that resident #027 had exhibited previous responsive behaviours. The progress notes indicated that resident #027 had a specific responsive behaviour as early as July 2015 and displayed responsive behaviours towards another resident in August 2015 and in October 2015. It was also noted that a medication was ordered for resident #027 in October 2015 to decrease their responsive behaviours. Resident #027 continued to exhibit responsive behaviours in October and November 2015. The care plan that was in place prior to the December 2015 incident, did not include all of the resident's responsive behaviours.

The progress notes included the following;

July 2015 – resident #027 exhibited specific responsive behaviours towards another resident when they had wandered into their room.

August 2015 – resident #027 exhibited specific responsive behaviours towards another resident when they had wandered into their room.

October 2015 – resident #027 exhibited specific responsive behaviours towards another resident in a lounge area. Medication was administered to resident #027 for their behaviour.

October 2015 – medication was administered to resident #027 for their specific responsive behaviours towards their room mate.

October 2015 – Behavioural Supports Ontario (BSO) staff believed that resident #027's personal item was a trigger for their specific responsive behaviour. Medication was administered for their specific responsive behaviour.

November 2015 – resident exhibited a specific responsive behaviour for no apparent reason.

December 2015 – resident #015 informed staff that they were fearful of their roommate, resident #027 as they exhibited a specific responsive behaviour towards them on a daily basis.

December 2015 – resident #027 exhibited a specific responsive behaviour, resident was irrational and very confused.

December 2015 – resident #027 physically assaulted their roommate, resident #015.

During an interview with the Director of Care, they confirmed that resident #027 was noted to have an increase in responsive behaviours during the month of October and November 2015.

During an interview with the BSO RPN #108, they stated that they were unsure when resident #015 was referred to BSO; however, they reported that the resident had been

part of the BSO Program since October 2015. BSO RPN #108 indicated that the BSO staff did not complete any assessments for resident #027 until just prior to the last incident that occurred in December 2015. The BSO RPN #108 verified that they did not participate in the development of the care plan to identify any behavioural triggers or interventions. They indicated that after the incident in October 2015, they did believe that a trigger to resident #027's specific responsive behaviour was their personal item. The BSO RPN #108 also confirmed that they should have completed assessments on resident #027 sooner, when the resident's behaviours started and then they would have been able to assist the staff with managing the responsive behaviours. [s. 53. (4) (c)]

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:

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. (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 licensee has failed to ensure that the care plan set out clear directions to staff and others who provided direct care to resident's #013 and #021.

During an interview on March 30, 2016 with resident #013, they reported to the Inspector that although they did not wear their dentures often, they would appreciate mouth care which they had not been receiving by staff.

Inspector #627 reviewed the resident's care plan dated March 11, 2016, and was unable to locate specific oral care interventions.

During an interview with PSW #118, they stated that resident #013 was to be provided their dentures which they refused to wear most days, however, they were unable to describe the type of mouth care that the resident was to receive. The Inspector and PSW #118 reviewed the most current care plan and PSW #118 confirmed that the care plan had no clear directions for resident #013's mouth care.

During an interview with RN #109, they also confirmed that the care plan had no clear directions for staff and others who provided direct care to the resident #013 in regards to their mouth care and it should have. [s. 6. (1) (c)]

2. Inspector #613 reviewed a Critical Incident (CI) that was submitted to the Director in October 2015. The CI identified that a Personal Assistance Services Device (PASD) had been improperly used as a restraint for resident #021.

The Inspector completed a health care record review for resident #021. The Physician Order Sheets identified that an order was received in December 2013 for a device for positioning and placing personal items on. The device could be removed by the resident on their own, or when they asked staff to remove it. The order was in place at time of the incident. The care plan at the time of the incident was reviewed and identified an intervention for the use of the device as a PASD. There was no order for the device to be used as a restraint.

During an interview on April 5, 2016 with the Director of Care (DOC), they reported to the Inspector that in October 2015, they had heard resident #021 yelling out and upon their arrival to the dining room they observed resident #021 sitting in their wheelchair with the device caught under the side of the table. The resident was pushing their knees against the bottom of the device attempting to remove it. The device had a seat belt strap that had been tied with three knots at the back of resident's wheelchair. The DOC confirmed that this was not the device ordered for resident #021. The DOC also confirmed that PSW #105 did not follow the home's policy or resident's care plan.

During an interview on April 6, 2016 with PSW #105, they confirmed that they had tied the seat belt strap attached to the device behind the residents wheelchair to prevent them from falling, as the resident was at risk for falls and they did not want the resident to fall on their shift. PSW #105 admitted they did not know about the care plan intervention

to have the device on the chair, but not secured. PSW #105 confirmed they had not followed resident #021's care plan or the home's policy on the day of the incident.

As a result of this incident, resident #021 sustained reddened areas to both knees. PSW #105 was disciplined for not following facility policy and resident #021's plan of care. [s. 6. (7)]

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 care plan sets out clear directions for resident #013's mouth care and to ensure that the care set out in the plan of care for resident #021's PASD is provided as specified, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident-staff communication response system that was easily seen, accessed, and used by residents, staff and visitors was available at all times.

During the Resident Quality Inspection (RQI), Inspectors observed resident #025 on numerous occasions in their bed which was situated in the hallway on the unit where they resided. The resident did not have any access to a call bell at anytime while their bed was in the hallway.

Inspector #542 reviewed resident #025's most recent care plan which indicated that their bed was kept in the hallway throughout the night and that the family was aware that resident #025 had no access to a call bell while they were in the hallway.

During an interview with the Director Of Care (DOC) and Assistant Director Of Care (ADOC), they both verified that resident #025 did not have access to a call bell while their bed was in the hallway and that their family was aware. They also verified that no other alternatives to a call bell had been tried.

During an interview with the BSO RPN #108, they informed Inspector #542 that resident #025 had been sleeping out in the hallway for a couple of years and never had access to a call bell while in the hallway. [s. 17. (1) (a)]

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 a resident-staff communication response system that is easily seen, accessed, and used by residents, staff and visitors is available for all residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an annual dental assessment and other preventive dental services were offered to resident's #023 and #006.

Inspector #627 reviewed a complaint that was submitted to the Director that indicated an allegation of improper oral care and no offering of an annual dental assessment for resident #023.

During an interview with a family member, they reported that resident #023 had not been offered any dental care assessment until February 2015. The resident had been admitted to the home in January 2009.

The Inspector reviewed resident #023's archived health care records that revealed an Admission Dental Assessment Consent form dated February 2015.

A review of the progress notes revealed that an initial professional dental assessment and consent was received in February 2015.

During an interview with the Assistant Director of Care, they confirmed that there was no documentation that indicated resident #023 had been offered an annual dental assessment prior to 2015. [s. 34. (1) (c)]

2. Inspector #613 completed a health care record review and noted on resident #006's paper chart, a consent for annual dental assessment signed by the resident in January 2011. However, there was no documentation on the Point Click Care (PCC) computer chart or paper chart to identify that an annual dental assessment or other preventive dental services had been offered. RN #106 verified to the Inspector that there was no documentation in the resident's health care records.

During an interview on April 7, 2016 with the Administrator, they confirmed that the Dental Hygienist had a contracted service with the home and was to offer annual dental assessments to the residents. The Administrator stated the Dental Hygienist was supposed to document in PCC when their services were provided to the residents.

During an interview on April 7, 2016 with the Director of Care, they confirmed there was no documentation in PCC to confirm that an annual dental assessment had been offered to resident #006. [s. 34. (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 an annual dental assessment and other preventive dental services are offered to resident's #023 and #006, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

On April 30, 2016, Inspector #627 observed an unsafe assistive device with a grab bar leaning outward in a room. The Inspector was able to move both grab bars on the assistive device approximately eight inches in both directions.

During an interview with PSW #114, they stated that when an assistive device was found to be unsafe or in need of repair, the procedure was for staff to report the issue to the registered staff or write it in the maintenance log book which was located in the BSO office, on the second floor. The Inspector and PSW #114 proceeded to examine another assistive device in another room. When the Inspector attempted to move the assistive device, the Inspector was able to move both grab bars approximately 3 to 4 inches. As well, the Inspector and PSW #114 examined the assistive device in a room together. The Inspector was able to move both grab bars on the assistive device approximately

eight inches. PSW #114 confirmed that both assistive devices did not appear to be secure and this should have been reported to the maintenance department by staff according to the home's procedure.

During an interview with Maintenance staff #115, they reported to the Inspector that the assistive devices were inspected yearly. Maintenance staff #115 reported to the Inspector the procedure for staff if they noted a defective or unsafe assistive device, staff were to document their findings in the maintenance log books that were located on both second and third floors, which maintenance checked log books daily. Maintenance staff #115 checked the assistive devices in both rooms and confirmed that the assistive devices did not appear to be secure and stated this should have been reported to the maintenance department by staff according to the home's procedure.

Inspector #627 reviewed the log book located in the BSO office on the second floor from August 28, 2015 to the present date which failed to reveal any notation of the unsafe assistive devices in either rooms.

During an interview with the Support Service Manager #116, they stated that all resident's transfer aids were inspected yearly and the results were documented on the Resident Area Checklist-Procedure Number 1165. Support Service Manager #116 was unable to provide the Inspector with a completed Resident Area Checklist-Procedure Number 1165 for the 2016 year, or any previous year. As well, Support Service Manager #116 stated that they had examined the assistive devices with the Program Manager #117 in both rooms and confirmed that the assistive devices were not secure and should have been reported to the maintenance department as per the home's procedure to ensure the assistive devices were kept in good repair. [s. 90. (2) (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 that procedures are developed and implemented to ensure that all equipment, devices, assistive aids, versa frames and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed immediately of the suspicion of abuse that resulted in harm or a risk of harm resident #020.

Inspector #613 reviewed a Critical Incident (CI) that was reported to the Director. The CI identified that resident #020 may have been abused in a room when care was provided by their family member. The CI stated that resident #029 reported to an Interdisciplinary Team Member #119 in January 2016, that when resident #020's family member was in a room assisting resident #020 with their care, the family member abused resident #020 and they thought they had heard a slapping sound. The Interdisciplinary Team Member #119 reported the alleged abuse to the Assistant Director of Care (ADOC) in January 2016 who was in charge of the home as the Director of Care and the Administrator were out of the building.

The incident occurred in January 2016. The CI was submitted to the Director in January 2016, one day late.

During an interview on April 7, 2016 with the Assistant Director of Care (ADOC), they reported that resident #020 had no physical effects from the incident. The ADOC also stated that resident #020 had been unable to respond to questions regarding the alleged incident. The ADOC confirmed that they had not followed the home's policy or the Long Term Care Homes Act and Regulations for reporting suspected abuse immediately.

During an interview on April 7, 2016 with the Administrator, they confirmed that the home was late with reporting the alleged abuse and the ADOC should have reported on the date the alleged incident had occurred. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing resident #008's care was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to resident #008 and their substitute decision-maker, if any.

During an interview with resident #008's family member, they informed Inspector #613 that they did not recall having a six week care conference after resident #008's admission in November 2015.

The Inspector reviewed the resident's electronic chart on Point Click Care and paper chart, and noted that there was no documentation to identify that a six week care conference of the interdisciplinary team was held following resident #008's admission.

During an interview on April 6, 2016 with the Director of Care, they reported to the Inspector that the six week care conference was scheduled for December 2015 but it had not been completed due to resident #008's family being unable to attend on the scheduled date. The DOC confirmed that the six week care conference had not been completed nor had the date been rescheduled and should have been.

During an interview on April 7, 2016 with the Administrator, they confirmed that the six week care conference post resident admission had been cancelled by resident #008's family and had not been rescheduled by the home. [s. 27. (1)]

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

---

Issued on this 8th day of July, 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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613), JENNIFER LAURICELLA (542), SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2016_395613_0004
Log No. / Registre no:	005680-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 13, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE VAN DAELE 39 Van Daele Street, Sault Ste Marie, ON, P6B-4V3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Diana Stenlund

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) (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:

a) Ensure behavioural triggers are identified for residents displaying responsive behaviours and are documented on the residents' care plans.

b) Ensure strategies are developed for minimizing or managing residents displaying responsive behaviours and how staff will ensure the safety of all other residents. These strategies are to be written in the residents care plans.

c) Ensure a referral is made to the appropriate specialized resource for residents with unmanageable responsive behaviours and those who present a safety risk to other residents.

d) Ensure actions are taken to respond to the needs of residents, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

e) Ensure all staff who provide direct care to residents are trained in behaviour management and mental heath issues, including caring for persons with dementia.

Grounds / Motifs :

1. The licensee has failed to ensure that the actions taken to meet the needs of resident #027 with responsive behaviours included assessments, reassessments, interventions and documentation of the resident`s responses to the interventions.

Inspector #542 reviewed a complaint submitted to the Director that indicated resident #015 was physically assaulted by resident #027 in December 2015. A Critical Incident (CI) was also submitted to the Director by the home, which identified that resident #027 had exhibited specific responsive behaviours towards resident #015. A staff member intervened and told resident #027 to stop, and then resident #027 exhibited different responsive behaviours towards resident #015. Another staff member assisted and resident #027 was removed from their room.

A closed health care record review for resident #027 was completed. The Inspector reviewed the assessments on Point Click Care (PCC) and was unable to determine if resident #027 had been assessed with regards to their responsive behaviors. The Inspector reviewed the admission assessment that was completed by Community Care Access Centre which outlined that resident #027 had exhibited previous responsive behaviours. The progress notes indicated that resident #027 had a specific responsive behaviour as early as July 2015 and displayed responsive behaviours towards another resident in August 2015 and in October 2015. It was also noted that a medication was ordered for resident #027 in October 2015 to decrease their responsive behaviours. Resident #027 continued to exhibit responsive behaviours in October and November 2015. The care plan that was in place prior to the December 2015 incident, did not include all of the resident's responsive behaviours.

The progress notes included the following;

July 2015 – resident #027 exhibited specific responsive behaviours towards another resident when they had wandered into their room.

August 2015 – resident #027 exhibited specific responsive behaviours towards another resident when they had wandered into their room.

October 2015 – resident #027 exhibited specific responsive behaviours towards another resident in a lounge area. Medication was administered to resident #027 for their behaviour.

October 2015 – medication was administered to resident #027 for their specific responsive behaviours towards their room mate.

October 2015 – Behavioural Supports Ontario (BSO) staff believed that resident #027's personal item was a trigger for their specific responsive behaviour. Medication was administered for their specific responsive behaviour.

November 2015 – resident exhibited a specific responsive behaviour for no apparent reason.

December 2015 – resident #015 informed staff that they were fearful of their roommate, resident #027 as they exhibited a specific responsive behaviour towards them on a daily basis.

December 2015 – resident #027 exhibited a specific responsive behaviour, resident was irrational and very confused.

December 2015 – resident #027 physically assaulted their roommate, resident #015.

During an interview with the Director of Care, they confirmed that resident #027 was noted to have an increase in responsive behaviours during the month of October and November 2015.

During an interview with the BSO RPN #108, they stated that they were unsure when resident #015 was referred to BSO; however, they reported that the resident had been part of the BSO Program since October 2015. BSO RPN #108 indicated that the BSO staff did not complete any assessments for resident #027 until just prior to the last incident that occurred in December 2015. The BSO RPN #108 verified that they did not participate in the development of the care plan to identify any behavioural triggers or interventions. They indicated that after the incident in October 2015, they did believe that a trigger to resident #027's specific responsive behaviour was their personal item. The BSO RPN #108 also confirmed that they should have completed assessments on resident #027 sooner, when the resident's behaviours started and then they would have been able to assist the staff with managing the responsive behaviours.

The scope of this issue was isolated to one resident demonstrating responsive

behaviours without actions taken for assessments, reassessments, interventions and documentation of the resident's responses to the interventions to minimize or manage their behaviours. There was no previous non compliance related to this; however, the severity was determined to be actual harm or risk of harm to the health, safety and well-being of resident #015 and any other resident of the home. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 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 soins 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 soins 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 13th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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