Ontario

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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 1, 2019	2019_671684_0035	011706-19, 016523-19, 016524-19	Follow up

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street THUNDER BAY ON P7B 5G7

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

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

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

SHELLEY MURPHY (684), AMY GEAUVREAU (642), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 21-25, 2019.

The following intakes were inspected upon during this Follow Up Inspection:

-One intake related to compliance order (CO) #003, from inspection report #2019_633577_0010, regarding r. 48 (1), of the O. Reg. 79/10, specific to weekly skin and wound assessments;
-One intake related to CO #001, from inspection report #2019_746692_0019, regarding s. 19 (1), of the Long-Term Care Homes Act, 2007, specific to abuse; and,
-One intake related to CO #002, from inspection report ##2019_746692_0019, regarding r. 53 (4), of the O. Reg. 79/10, specific to responsive behaviours.

Complaint inspection #2019_671684_0037 and Critical Incident System inspection #2019_671684_0036 were conducted concurrently with this Critical Incident System inspection.

PLEASE NOTE: Non-compliance of a Compliance Order (CO) related to r. 53 (4) b of the O. Reg 79/10, were identified in a concurrent inspection #2019_671684_0036 and #2019_671684_0037 have been issued in this report.

During the course of the inspection, the inspector(s) spoke with the Regional Director, Administrator, Clinical Managers (CM), Physio Therapist (PT), Psychogeriatric Resource Consultant (PRC), Social Worker (SW), Therapeutic Recreationist (TR), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Contractors, residents and families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, audits, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_746692_0019	684
O.Reg 79/10 s. 48. (1)	CO #003	2019_633577_0010	684

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	Légende 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 for each resident who demonstrated responsive behaviours, strategies were developed and implemented to respond to those behaviours, where possible.

A Critical Incident System (CIS) report was submitted to the Director, which identified resident to resident abuse. The report indicated that resident #004 was found near resident #002 and was noted to have an injury.

During a review of resident #002's care plan which was in effect at the time that resident #004 sustained an injury, Inspector #577 noted that the care plan indicated that staff were to utilize specific interventions to prevent triggers for resident #002.

Inspector #577 reviewed the non-pharmacological strategies for resident #002, developed by Psychogeriatric Resource Consultant (PRC), which indicated responsive behaviour triggers for resident #002, and interventions staff were to utilize to prevent triggers for resident #002.

A review of resident #002's progress notes by Inspector #577 indicated a number of progress notes from a number of different days where resident #002 expressed concerns about triggers for their responsive behaviours.

Inspector #577 reviewed the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment, which identified resident #002's Cognitive Performance Scale (CPS).

A review of the home's policy, "Responsive Behaviours – RC-17-01-04", revised February 2017 by Inspector #577, indicated that staff were to be familiar with the residents' plan of care, the specific interventions related to behaviours and were to be consistent in the application and implementation of these interventions.

During observations on a specified date in 2019, Inspector #577 observed resident #002 to have one intervention in place to prevent their responsive behaviour triggers; however, a second intervention was not implemented at that time.

A number of different observations were conducted on a specified date in 2019, at various times by Inspector #577 for resident #002. During the observations, resident #002 had responsive behaviour interventions in place; however, one intervention was not being utilized correctly.

Inspector #577 observed at a specific time on a specified date in 2019, and noted that resident #002 had a intervention in place, but it was not being utilized correctly.

Inspector #577 spoke with Personal Support Worker (PSW) #137, and they confirmed that the intervention was not in place for resident #002, and didn't know why it wasn't in place.

During an interview with Registered Practical Nurse (RPN) #120, they reported to Inspector #577, that resident #002 would have responsive behaviours from specific triggers. They identified specific interventions to help prevent responsive behaviours for resident #002.

Inspector #577 interviewed the PRC #114, they identified that resident #002 had specific triggers for their responsive behaviours.

During an interview with resident #002, they reported to Inspector #577 that they've never had a specific intervention in place, and they were not opposed to having this.

During an interview with Clinical Manager (CM) #121, they reported to Inspector #577 that there had been responsive behaviours when certain triggers occurred with resident #002. The Inspector and the CM reviewed a CIS report related to resident #002 and their responsive behaviours. The CM had indicated in the CIS report that they spoke with the resident's POA and suggested a specific intervention be put into place to prevent resident #002 from being triggered to exhibit responsive behaviours, and the POA did not

consent to the safety measure. They further reported that they were unsure whether the intervention had ever been initiated.

During an interview with the Administrator, they reported to Inspector #577 that staff did not require consent for a specified intervention, as it was a safety measure.

During an interview with Regional Director, Inspector #577 reviewed the documentation from a CIS report related to resident #002 and their responsive behaviours; where a specific intervention had been suggested to prevent triggers for resident #002, and the POA didn't consent. They confirmed that this safety strategy wasn't implemented and had been documented in the care plan for resident #002. [s. 53. (4) (b)]

2. A CI report was submitted to the Director, for alleged resident to resident physical abuse. The CI report indicated that staff were made aware of an incident between resident #014 and resident #015. The CI report further indicated that both residents sustained injuries from the incident.

During observations of resident #015's room on two specified dates in 2019, Inspector #690 observed that an intervention was not in place.

A review of resident #015's electronic progress notes indicated that an incident occurred between resident #015 and resident #014. The progress notes further indicated that a specific intervention that was to be utilized for both residents.

A review of resident #015's electronic care plan indicated that they had responsive behaviours and that staff were to ensure that the intervention was in place as specified.

In an interview with PSW #110, they indicated that resident #015 had responsive behaviours, and that they had a specific intervention that was to be used as specified.

In an interview with the RPN #116, they indicated that resident #015 had responsive behaviours, and they were to have an intervention in place as specified. RPN #116 further indicated that the intervention was not in place and that it should have been.

In an interview with Inspector #690, CM #132, indicated that resident #015 had responsive behaviours. Together, Inspector #690 and CM #132 reviewed resident #015's care plan and CM #132 indicated that according to the care plan, the resident was to have a certain intervention implemented as specified. CM #132 indicated that if the

intervention was not in place as specified, that care was not being provided as indicated in the care plan, and that it should be. [s. 53. (4) (b)]

3. The licensee has failed to ensure that, for each resident that demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented.

Compliance order #002 was served to the licensee on August 20, 2019, from inspection report 2019_746692_0019, related to section 53 (4), of the Long-Term Care Home's Act (LTCHA) 2007, and had a compliance due date of October 14, 2019. The compliance order stated:
The licensee must be compliant with s. 53 (4) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must:

a) Develop and implement a process to ensure that staff are completing Dementia Observation System (DOS) documentation, as per the home's policies and procedures.
b) Develop and conduct audits to ensure that DOS documentation is being completed as required and maintain a record of the audits that are conducted.

a) Inspector #690 conducted a review of the home's completed audits of the DOS documentation for resident #026. The audit identified that there was incomplete documentation on a specified date in 2019, from one specified time to another, and a second specified date in 2019, from one specified time to another. The Inspector identified two documents dated in 2019, attached to the audit from CM #132 to the PSW's that were responsible for completing the missing documentation. The documents identified the missing documentation and indicated that the documentation was to be completed as soon as possible.

Inspector #690 viewed clinical records for resident #026 and identified a physician's order from a specified date in 2019, that indicated that resident #026 was to have DOS documentation completed for a number of days.

b) Inspector #690 conducted a review of the DOS documentation audits for resident #027. The audit identified that there was incomplete documentation on a specific date in 2019, from one specified time to another. The Inspector identified a document from a

specific date in 2019, from CM #132, to the PSW that was responsible for the DOS documentation on the specified date in 2019. The document indicated that there was missing documentation and that the documentation was to be completed as soon as possible.

A review of the clinical records for resident #027 by Inspector #690, identified a physician's order from a specified date in 2019, that indicated that resident #027 was to have DOS documentation completed for a number of days.

c) Inspector #690 conducted a review of the home's completed audits of the DOS documentation for resident #028. The audit identified that there was incomplete documentation on a specified date in 2019, from one specified time to another. The Inspector identified a document with a specific date in 2019, from CM #132, to the PSW that was responsible for the documentation on the specified date in 2019. The document identified the missing documentation and that the documentation was to be completed as soon as possible.

Inspector #690 reviewed the clinical records for resident #028 and identified a physician's order from a specified date in 2019, that indicated that resident #028 was to have DOS documentation completed for a number of days.

d) Inspector #690 conducted a review of the DOS documentation audits that were to be completed for resident #029. The audit identified that there was incomplete documentation on a specified date in 2019, from one specified time to another. The Inspector reviewed a document from a specified date in 2019, from CM #121, to PSW #123 who was responsible for the documentation on two specific dates in 2019. The document identified the missing documentation and that the documentation was to be completed as soon as possible.

A review of the clinical records for resident #029 by Inspector #690 identified a physician's order from a specified date in 2019, that indicated that resident #029 was to have DOS documentation completed for a number of days.

e) Inspector #690 observed the documentation record on a specified day in 2019, for resident #030 that indicated the DOS documentation was started on a specified date in 2019, at a specified time. The Inspector observed the document on a specified day in 2019, at a specified time, and there was no documentation completed for this day from one specified time to another.

Inspector #690 reviewed the clinical records for resident #030 and noted a physician's order from a specified date in 2019, that indicated that the resident was to have DOS documentation completed for a number of days.

f) Inspector #690 observed a DOS documentation record on a specified day in 2019, for resident #031 that indicated the specific documentation was started on a specified day in 2019 at a specific hour. The Inspector observed the document on a specified date in 2019, at a specified time and there was no documentation completed for the specified date from one specified time to another.

Inspector #690 viewed the clinical records for resident #031 and identified a physician's order from a specified date in 2019, that stated the resident was to have DOS documentation completed for a number of days.

A review of the home's policy titled "Mental health and responsive behaviours-#LTC-3-51", dated July 2019, indicated that the DOS was used to observe behaviour over time (i.e. 5-7 days) and allowed for a thorough evaluation of any patterns of behaviour throughout the 24 hour period.

In separate interviews with Inspector #690, PSW #115, PSW #123, and PSW #126 indicated that PSW staff were responsible for completing the DOS documentation on residents and that the documentation should be completed at the time of the observation. PSW #123 indicated that they had been responsible for the DOS documentation on a specified date in 2019, for resident #026 on a certain shift. PSW #123 indicated that they received a document, and was verbally told by CM #132, that they had missed completing DOS documentation from one specified time frame to another. PSW #123 further indicated that the DOS documentation should be completed at the time that they were observing the resident and that they had completed the missing documentation on the following day. PSW #126 indicated that they were responsible for completing the DOS documentation for resident #030 and resident #031 on a specified date in 2019, for a number of hours. They indicated they had observed the two residents that day but that they had not completed the DOS documentation and they should have.

In an interview with Inspector #690, CM #132 indicated that they had been auditing DOS documentation and would follow up with the responsible staff members if there was any missing documentation. CM #132 indicated that they had documented or verbally spoken to the PSW's responsible for the missing documentation and directed the staff to

complete the documentation on their next shift. Together Inspector #690 and CM #132 reviewed the audits and DOS documentation for residents #026, #027, and #028, and CM #132 indicated that the DOS documentation had been completed when the staff returned to work their next shift. CM #132 further indicated that the DOS documentation should have been completed at the time of the observation.

In an interview with CM #121, they indicated that they audited the DOS documentation and would follow up with the responsible staff members if there was any missing documentation. CM #121 indicated that they had notified the PSW that was responsible for doing the DOS documentation for resident #029 and that the PSW had not replied to the notification. The DOS documentation remains incomplete for the two specified dates in 2019. CM #121 further indicated that the DOS documentation should be completed at the time of the observation and that it had not been.

In an interview with Inspector #690, the Administrator indicated that the home had been auditing the DOS documentation as part of the follow up to the compliance order. The Administrator indicated that DOS was only to be ordered by a Physician, Nurse Practitioner, or PRC and that Registered staff process the order and communicate to the PSW's when a resident required DOS documentation. The Administrator indicated that it was the expectation that the DOS documentation be completed by the PSW at the time of the observation, but at times, staff would complete it at the end of the shift as they would get input from other staff members about a resident's behaviours. Together Inspector #690 and the Administrator reviewed the DOS documentation for residents #026, #027, #028, #029, #030, and #031. The Administrator indicated that the documentation was not completed at the time of the observation and that it should have been. [s. 53. (4) (c)]

Additional Required Actions:

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

Issued on this 14th day of November, 2019

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

Ministère 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

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) :	SHELLEY MURPHY (684), AMY GEAUVREAU (642), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), TRACY MUCHMAKER (690)
Inspection No. / No de l'inspection :	2019_671684_0035
Log No. / No de registre :	011706-19, 016523-19, 016524-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 1, 2019
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sheila Clark

Ontario

Ministry of Health and Long-Term Care

Ministère 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

To St. Joseph's Care Group, 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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)

Linked to Existing Order / Lien vers ordre existant: 2019_746692_0019, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee must be compliant with r. 53 (4) of the O. Reg 79/10.

Specifically, the licensee must:

a) re-educated PSWs #115, #123, #126 and all other PSW staff who were identified through home Dementia Observation System (DOS) documentation audits as not completing DOS documentation as per the home's policy.

b) maintain audits to ensure that DOS documentation is being completed as required.

c) ensure care plan interventions are implemented for resident #002, resident #015 and all other residents with responsive behaviours.

c) Maintain a record of the audits conducted.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident who demonstrated responsive behaviours, strategies were developed and implemented to respond to those behaviours, where possible.

A Critical Incident System (CIS) report was submitted to the Director, which identified resident to resident abuse. The report indicated that resident #004 was found near resident #002 and was noted to have an injury.

During a review of resident #002's care plan which was in effect at the time that resident #004 sustained an injury, Inspector #577 noted that the care plan indicated that staff were to utilize specific interventions to prevent triggers for resident #002.

Inspector #577 reviewed the non-pharmacological strategies for resident #002, developed by Psychogeriatric Resource Consultant (PRC), which indicated responsive behaviour triggers for resident #002, and interventions staff were to utilize to prevent triggers for resident #002.

A review of resident #002's progress notes by Inspector #577 indicated a number of progress notes from a number of different days where resident #002 expressed concerns about triggers for their responsive behaviours.

Inspector #577 reviewed the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment, which identified resident #002's Cognitive Performance Scale (CPS).

A review of the home's policy, "Responsive Behaviours – RC-17-01-04", revised February 2017 by Inspector #577, indicated that staff were to be familiar with the residents' plan of care, the specific interventions related to behaviours and were to be consistent in the application and implementation of these interventions.

During observations on a specified date in 2019, Inspector #577 observed resident #002 to have one intervention in place to prevent their responsive behaviour triggers; however, a second intervention was not implemented at that time.

A number of different observations were conducted on a specified date in 2019, at various times by Inspector #577 for resident #002. During the observations, resident #002 had responsive behaviour interventions in place; however, one intervention was not being utilized correctly.

Inspector #577 observed at a specific time on a specified date in 2019, and noted that resident #002 had a intervention in place, but it was not being utilized correctly.

Inspector #577 spoke with Personal Support Worker (PSW) #137, and they confirmed that the intervention was not in place for resident #002, and didn't know why it wasn't in place.

During an interview with Registered Practical Nurse (RPN) #120, they reported to Inspector #577, that resident #002 would have responsive behaviours from specific triggers. They identified specific interventions to help prevent responsive behaviours for resident #002.

Inspector #577 interviewed the PRC #114, they identified that resident #002 had specific triggers for their responsive behaviours.

During an interview with resident #002, they reported to Inspector #577 that they've never had a specific intervention in place, and they were not opposed to having this.

During an interview with Clinical Manager (CM) #121, they reported to Inspector #577 that there had been responsive behaviours when certain triggers occurred with resident #002. The Inspector and the CM reviewed a CIS report related to resident #002 and their responsive behaviours. The CM had indicated in the CIS report that they spoke with the resident's POA and suggested a specific intervention be put into place to prevent resident #002 from being triggered to exhibit responsive behaviours, and the POA did not consent to the safety measure. They further reported that they were unsure whether the intervention had ever been initiated.

During an interview with the Administrator, they reported to Inspector #577 that staff did not require consent for a specified intervention, as it was a safety measure.

During an interview with Regional Director, Inspector #577 reviewed the documentation from a CIS report related to resident #002 and their responsive

behaviours; where a specific intervention had been suggested to prevent triggers for resident #002, and the POA didn't consent. They confirmed that this safety strategy wasn't implemented and had been documented in the care plan for resident #002.

During an interview with Registered Practical Nurse (RPN) #120, they reported to Inspector #577, that resident #002 would have responsive behaviours when a co-resident wandered into their room and identified that was a trigger; reported that an altercation would occur and interventions included a yellow wander strip and a door screamer.

Inspector #577 interviewed the PRC #114, they identified that resident #002 was triggered by people getting into their personal space.

During an interview with resident #002, they reported to Inspector #577 that they've never had an alarm on their door, and were not opposed to having one.

During an interview with Clinical Manager (CM) #121, they reported to Inspector #577 that there had been physical altercations when co-residents wandered into resident #002's room. The Inspector and the CM reviewed a CIS report related to resident #002 and their responsive behaviours. The CM had indicated on the CIS report that they spoke with the resident's POA and suggested that a door alarm be placed on resident's door to try to deter co-residents from wandering into their room, and the POA did not consent to the safety measure. They further reported that they were unsure whether the door screamer alarm had ever been initiated.

During an interview with the Administrator, they reported to Inspector #577 that staff did not require consent for a screamer door alarm, as it was a safety measure.

During an interview with Regional Director, Inspector #577 reviewed the documentation for a CIS report related to resident #002 and their responsive behaviours; where a door alarm had been suggested to deter residents from wandering into resident #002's room and the POA didn't consent. They confirmed that this safety strategy wasn't implemented and had been documented in the care plan for resident #002. (684)

2. A CI report was submitted to the Director, for alleged resident to resident physical abuse. The CI report indicated that staff were made aware of an incident between resident #014 and resident #015. The CI report further indicated that both residents sustained injuries from the incident.

During observations of resident #015's room on two specified dates in 2019, Inspector #690 observed that an intervention was not in place.

A review of resident #015's electronic progress notes indicated that an incident occurred between resident #015 and resident #014. The progress notes further indicated that a specific intervention that was to be utilized for both residents.

A review of resident #015's electronic care plan indicated that they had responsive behaviours and that staff were to ensure that the intervention was in place as specified.

In an interview with PSW #110, they indicated that resident #015 had responsive behaviours, and that they had a specific intervention that was to be used as specified.

In an interview with the RPN #116, they indicated that resident #015 had responsive behaviours, and they were to have an intervention in place as specified. RPN #116 further indicated that the intervention was not in place and that it should have been.

In an interview with Inspector #690, CM #132, indicated that resident #015 had responsive behaviours. Together, Inspector #690 and CM #132 reviewed resident #015's care plan and CM #132 indicated that according to the care plan, the resident was to have a certain intervention implemented as specified. CM #132 indicated that if the intervention was not in place as specified, that care was not being provided as indicated in the care plan, and that it should be. (684)

3. The licensee has failed to ensure that, for each resident that demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the

resident's responses to interventions were documented.

Compliance order #002 was served to the licensee on August 20, 2019, from inspection report 2019_746692_0019, related to section 53 (4), of the Long-Term Care Home's Act (LTCHA) 2007, and had a compliance due date of October 14, 2019. The compliance order stated:
The licensee must be compliant with s. 53 (4) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must:

a) Develop and implement a process to ensure that staff are completing Dementia Observation System (DOS) documentation, as per the home's policies and procedures.
b) Develop and conduct audits to ensure that DOS documentation is being completed as required and maintain a record of the audits that are conducted.

a) Inspector #690 conducted a review of the home's completed audits of the DOS documentation for resident #026. The audit identified that there was incomplete documentation on a specified date in 2019, from one specified time to another, and a second specified date in 2019, from one specified time to another. The Inspector identified two documents dated in 2019, attached to the audit from CM #132 to the PSW's that were responsible for completing the missing documentation. The documents identified the missing documentation and indicated that the documentation was to be completed as soon as possible.

Inspector #690 viewed clinical records for resident #026 and identified a physician's order from a specified date in 2019, that indicated that resident #026 was to have DOS documentation completed for a number of days.

b) Inspector #690 conducted a review of the DOS documentation audits for resident #027. The audit identified that there was incomplete documentation on a specific date in 2019, from one specified time to another. The Inspector identified a document from a specific date in 2019, from CM #132, to the PSW that was responsible for the DOS documentation on the specified date in 2019. The document indicated that there was missing documentation and that the documentation was to be completed as soon as possible.

A review of the clinical records for resident #027 by Inspector #690, identified a physician's order from a specified date in 2019, that indicated that resident #027 was to have DOS documentation completed for a number of days.

c) Inspector #690 conducted a review of the home's completed audits of the DOS documentation for resident #028. The audit identified that there was incomplete documentation on a specified date in 2019, from one specified time to another. The Inspector identified a document with a specific date in 2019, from CM #132, to the PSW that was responsible for the documentation on the specified date in 2019. The document identified the missing documentation and that the documentation was to be completed as soon as possible.

Inspector #690 reviewed the clinical records for resident #028 and identified a physician's order from a specified date in 2019, that indicated that resident #028 was to have DOS documentation completed for a number of days.

d) Inspector #690 conducted a review of the DOS documentation audits that were to be completed for resident #029. The audit identified that there was incomplete documentation on a specified date in 2019, from one specified time to another. The Inspector reviewed a document from a specified date in 2019, from CM #121, to PSW #123 who was responsible for the documentation on two specific dates in 2019. The document identified the missing documentation and that the documentation was to be completed as soon as possible.

A review of the clinical records for resident #029 by Inspector #690 identified a physician's order from a specified date in 2019, that indicated that resident #029 was to have DOS documentation completed for a number of days.

e) Inspector #690 observed the documentation record on a specified day in 2019, for resident #030 that indicated the DOS documentation was started on a specified date in 2019, at a specified time. The Inspector observed the document on a specified day in 2019, at a specified time, and there was no documentation completed for this day from one specified time to another.

Inspector #690 reviewed the clinical records for resident #030 and noted a physician's order from a specified date in 2019, that indicated that the resident

was to have DOS documentation completed for a number of days.

f) Inspector #690 observed a DOS documentation record on a specified day in 2019, for resident #031 that indicated the specific documentation was started on a specified day in 2019 at a specific hour. The Inspector observed the document on a specified date in 2019, at a specified time and there was no documentation completed for the specified date from one specified time to another.

Inspector #690 viewed the clinical records for resident #031 and identified a physician's order from a specified date in 2019, that stated the resident was to have DOS documentation completed for a number of days.

A review of the home's policy titled "Mental health and responsive behaviours-#LTC-3-51", dated July 2019, indicated that the DOS was used to observe behaviour over time (i.e. 5-7 days) and allowed for a thorough evaluation of any patterns of behaviour throughout the 24 hour period.

In separate interviews with Inspector #690, PSW #115, PSW #123, and PSW #126 indicated that PSW staff were responsible for completing the DOS documentation on residents and that the documentation should be completed at the time of the observation. PSW #123 indicated that they had been responsible for the DOS documentation on a specified date in 2019, for resident #026 on a certain shift. PSW #123 indicated that they received a document, and was verbally told by CM #132, that they had missed completing DOS documentation from one specified time frame to another. PSW #123 further indicated that the DOS documentation should be completed at the time that they were observing the resident and that they had completed the missing documentation on the following day. PSW #126 indicated that they were responsible for completing the DOS documentation for resident #030 and resident #031 on a specified date in 2019, for a number of hours. They indicated they had observed the two residents that day but that they had not completed the DOS documentation and they should have.

In an interview with Inspector #690, CM #132 indicated that they had been auditing DOS documentation and would follow up with the responsible staff members if there was any missing documentation. CM #132 indicated that they had documented or verbally spoken to the PSW's responsible for the missing

documentation and directed the staff to complete the documentation on their next shift. Together Inspector #690 and CM #132 reviewed the audits and DOS documentation for residents #026, #027, and #028, and CM #132 indicated that the DOS documentation had been completed when the staff returned to work their next shift. CM #132 further indicated that the DOS documentation should have been completed at the time of the observation.

In an interview with CM #121, they indicated that they audited the DOS documentation and would follow up with the responsible staff members if there was any missing documentation. CM #121 indicated that they had notified the PSW that was responsible for doing the DOS documentation for resident #029 and that the PSW had not replied to the notification. The DOS documentation remains incomplete for the two specified dates in 2019. CM #121 further indicated that the DOS documentation should be completed at the time of the observation and that it had not been.

In an interview with Inspector #690, the Administrator indicated that the home had been auditing the DOS documentation as part of the follow up to the compliance order. The Administrator indicated that DOS was only to be ordered by a Physician, Nurse Practitioner, or PRC and that Registered staff process the order and communicate to the PSW's when a resident required DOS documentation. The Administrator indicated that it was the expectation that the DOS documentation be completed by the PSW at the time of the observation, but at times, staff would complete it at the end of the shift as they would get input from other staff members about a resident's behaviours. Together Inspector #690 and the Administrator reviewed the DOS documentation for residents #026, #027, #028, #029, #030, and #031. The Administrator indicated that the documentation was not completed at the time of the observation and that it should have been.

The severity of this issue was determined to be a level two, as there was a risk of minimal harm or minimal risk to residents of the home. The scope of the issues was a level three, as it affected 65 percent of the residents reviewed. The home had a level five compliance history, as they had ongoing non-compliance with this section of the Ontario Regulation 79/10 which included;

-one written notification September 18, 2019 (2019_768693_0021);

-compliance order #002 issued August 20, 2019, with a compliance due date of October 14, 2019 (2019_746692_0019)

-one written notification February 12, 2019 (2019_768693_0002).
(690)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 1st day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shelley Murphy

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