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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 10, 2018	2018_724640_0007	003648-18, 003689-18	Complaint

Licensee/Titulaire de permis

King Nursing Home Limited
49 Sterne Street Bolton ON L7E 1B9

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

King Nursing Home
49 Sterne Street Bolton ON L7E 1B9

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

HEATHER PRESTON (640)

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): February 28, March 1, 9, 12, and 20, 2018.

The inspection included the following intakes;

Complaint Log #003689-18 related to allegation of abuse

Critical Incident Log #003648-18 related to allegation of abuse
Critical Incident Log #018895-17 related to allegation of abuse

Follow Up Log #000282-18 related to Compliance Order #001 from inspection #2017_482640_0018 regarding responsive behaviours

During the course of the inspection the LTCH Inspector toured the home, observed resident care, reviewed clinical records, reviewed the home's policy and procedure as they related to the inspection, reviewed education and training records, reviewed annual evaluations of related programs and interviewed staff and residents.

During the course of the inspection, the inspector(s) spoke with residents, families, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, Behavioural Support RPN, Wound and Skin Champion, Administrator, Director of Care, Assistant Director of Care and the Office Manager

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone.

For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, subject to subsection (2), a) the use of physical force by anyone other than a resident that caused injury or pain.

The home's policy "Prevention of Abuse and Neglect of a Resident", policy #VII-G_10.00 with a revised date of January 2015, stated that all residents had a right to dignity, respect and freedom from abuse and neglect. The Organization had a Zero Tolerance Policy for resident abuse or neglect. Abuse in that policy was defined as "Abuse of a resident by anyone that resulted in harm or a risk of harm to the resident."

1) On an identified date in August 2017 resident #003 reported to RPN #102 that a staff member was rough and caused altered skin integrity.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record of resident #003. The clinical record included a full assessment, completion of an incident report and initial assessments of the altered skin integrity and weekly thereafter until healed.

The Director of Care provided the home's internal investigative notes and findings to the LTCH Inspector. The home concluded that PSW #100 had used physical force toward resident #003 and the home took action.

During an interview with the LTCH Inspector and the Administrator, the Administrator acknowledged this incident met the definition of physical abuse.

2) On an identified date in February 2018, resident #002 reported to RPN #102 that a staff member came into the resident's room and was rough with the resident and yelled at them.

The Long-Term Care Homes (LTCH) Inspector interviewed the resident who confirmed the event.

During an interview with the DOC and the Administrator, they acknowledged the described incident did meet the definition of physical abuse.

3) On an identified date in February 2018, resident #001 was found to have responsive behaviours during the provision of care.

The LTCH Inspector interviewed the resident who described and demonstrated staff actions to them and showed them the injury as a result of the action.

The LTCH Inspector reviewed the written plan of care which directed staff what strategies and interventions to implement when a responsive behaviour occurred.

During the incident, staff noted an injury to the resident and RN #106 assessed the injury which required care.

During an interview with the Administrator by the LTCH Inspector, the Administrator acknowledged that staff actions resulted in an injury, constituted physical abuse. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure a written record was kept relating to each annual evaluation of the Responsive Behaviours Program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Long-Term Care Homes (LTCH) Inspector reviewed the home's "Quality Management – LTC Program/Committee Evaluation Tool" dated April 26, 2017, as presented by the Director of Care to the LTCH Inspector as the program's annual review. The review was for the period of March 2016 – March 2017.

The report included a section to document a summary of changes made to the program. Documented in this section were data related to the use of psychotropic medications and

did identify the home's goal was not met from the previous year. The LTCH Inspector identified that monthly Responsive Behaviour committee meetings would begin every month, staff huddles were to be implemented and the implementation of an antipsychotic reduction toolkit.

The document did not include any dates of implementation of the three new changes made to the program as noted above.

The LTCH Inspector reviewed the report with the DOC and the Administrator who acknowledged the report did not include the dates of the changes. [s. 53. (3) (c)]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to those behaviours.

1) On an identified date in February 2018, staff found resident #001 to have responsive behaviours during care.

The written plan of care dated February 2018, directed staff on strategies and interventions to implement when the resident demonstrated responsive behaviours.

During the review of the clinical records, the Long-Term Care Homes (LTCH) Inspector noted that two staff members did not implement the strategies or interventions for the resident.

During the incident, staff noted the resident had an injury and RN #106 assessed the altered skin integrity and noted it required care.

The home's policy "Responsive Behaviours-Management", policy #VII-F-10.20 with a revised date of October 2016, directed PSW staff to intervene using Gentle Persuasive Approach (GPA) techniques when they notice a change in a resident's behaviour.

PSW #100 informed the LTCH Inspector the plan of care directed staff on strategies and interventions to implement when the resident exhibited responsive behaviours and they had not implemented them at the time. They had not tried any other interventions.

2) On an identified date in February 2018, resident #001 was found to be exhibiting responsive behaviours.

The LTCH Inspector reviewed the clinical record and found the documentation did not include that interventions as per the plan of care were implemented for this situation.

The home's policy "Responsive Behaviours-Management", policy #VII-F-10.20 with a revised date of October 2016, directed staff to intervene using Gentle Persuasive Approach (GPA) techniques when they notice a change in a resident's behaviour.

During an interview with RN #106, they told the LTCH Inspector they had not tried any interventions related to this situation except for talking to the resident.

The RN confirmed they had not reviewed the written plan of care related to the interventions specific for the resident's responsive behaviours.

The licensee failed to ensure that strategies that were developed were implemented to respond to resident #001's behaviours. [s. 53. (4) (b)]

3. The licensee failed to ensure that for each resident demonstrating 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.

The licensee has failed to comply with compliance order (CO) #001from inspection #2017_482640_0018 served on November 17, 2017, with a compliance date of December 29, 2017.

The licensee was ordered to:

1. Ensure that resident #018 and resident #020 are reassessed regarding their responsive behaviours, including behavioural triggers, where possible.
2. Ensure that for each resident demonstrating responsive behaviours, including resident #018 and resident #020, strategies are developed and implemented to respond to these behaviours, where possible.

The licensee completed steps #1 and #2 for resident #018 and step #2 for resident #020.

In step #1 for resident #20, the licensee was required to reassess the resident. The

licensee failed to ensure the requirement of the order was met.

During the course of the inspection the Long-Term Care Homes (LTCH) Inspector reviewed the clinical record for the resident #020. The clinical record did not include a re-assessment of this resident from the date the Compliance Order was served up to and including March 20, 2018.

During an interview with RPN #107, they confirmed there were no re-assessments of resident #020 during the time frame above. The last known assessment was that of August 10, 2017, during a visit to an external organization.

The LTCH Inspector interviewed the Director of Care (DOC) who was not able to identify any re-assessments of resident #020 during the specific time frame as above.

The DOC acknowledged the home had not complied with CO #001 to reassess resident #020. [s. 53. (4) (c)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents and that the policy was complied with.

For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that caused physical injury or pain.

On an identified date in August 2017, resident #003 had been handled roughly by staff resulting in altered skin integrity.

The home's policy "Prevention of Abuse and Neglect of a Resident – Actual or Suspected", policy #VII-G-10.00(b) with a revised date of January 2015, directed staff to at a minimum, document and assess the resident status each shift for 72 hours following the incident.

The Long Term Care Homes (LTCH) Inspector reviewed the clinical record of resident #003 and found the resident's status had been assessed for 48 hours following the incident and they failed to assess the resident's status for the last 24 hours of the required 72 hour assessment period.

During an interview with RN #101, the home's Skin and Wound Lead, they confirmed it was an expectation of the home that the resident's status be assessed following the alleged abuse that caused altered skin integrity each shift for a total of 72 hours.

RN #101 acknowledged the home did not assess the status of resident #003 for the last 24 hours of the required 72 hour assessment period

The home failed to comply with their "Prevention of Abuse and Neglect of a Resident" policy. [s. 20. (1)]

Additional Required Actions:

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

WN #4: 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 failed to ensure that any suspicion of abuse of a resident and the information upon which it was based was immediately reported to the Director when the home had reasonable grounds to suspect that abuse of a resident had occurred that resulted in harm or a risk of harm to the resident.

For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that caused physical injury or pain.

On an identified date in February 2018, resident #002 informed RPN #102 that a staff member had allegedly physically abused them and yelled at them.

The home's policy "Prevention of Abuse and Neglect of a Resident", policy #VII-G-10.00 with a revised date of January 2015, directed all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents and families are "required to immediately report" any suspected or know incident of abuse to the Director of MOHLTC.

RPN #002 immediately began the checklist for investigation of alleged abuse of a resident and then presented the documentation to the Administrator and Director of Care (DOC) on the same identified date in February 2018.

The LTCH Inspector interviewed resident #002 who confirmed they had been physically hurt by a staff member which caused severe pain.

On an identified date in March 2018, the Long Term Care Homes (LTCH) Inspector requested a copy of the Critical Incident submitted to the Director for the allegation of abuse of resident #002. The DOC informed the LTCH Inspector the incident that occurred with resident #002 had not been reported to the Director.

During an interview of the Administrator and the DOC they acknowledged the home did not report this allegation of abuse to the Director.

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 the licensee shall ensure that any suspicion of abuse of a resident and the information upon which it is based is immediately reported to the Director when the home has reasonable grounds to suspect that abuse of a resident has occurred that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On an identified date in February 2018, resident #001 had an area of altered skin integrity.

The home's policy "Skin and Wound Care Management Protocol", policy #VII-G-10.80 with a revised date of April 2016, directed staff to conduct a skin assessment for a resident who had altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds using the wound management treatment plan and the weekly skin surveillance assessment document. For this type of wound, specifically the "Skin Wound Care Assessment" was to be initiated.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record of resident #001 and found there were no assessments of the altered skin integrity.

The LTCH Inspector interviewed RN #102, the home's Wound and Skin Lead who informed the LTCH Inspector it was expected that an assessment of new altered skin integrity was to occur using the form designed specifically for the assessment, then weekly thereafter.

During an interview with the Director of Care, they acknowledged the home failed to ensure an assessment was completed for resident #001's altered skin integrity. [s. 50. (2) (b) (i)]

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 the licensee shall ensure a resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

Issued on this 16th day of April, 2018

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) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2018_724640_0007
Log No. / No de registre :	003648-18, 003689-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 10, 2018
Licensee / Titulaire de permis :	King Nursing Home Limited 49 Sterne Street, Bolton, ON, L7E-1B9
LTC Home / Foyer de SLD :	King Nursing Home 49 Sterne Street, Bolton, ON, L7E-1B9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janice King

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically the licensee must ensure:
1) That residents #001, #002 and #003 and any other resident are protected from physical abuse by anyone.
2) That the identified staff are provided face to face instruction related to Abuse and Neglect of residents, reporting requirements when abuse or neglect is suspected and action the home will take when abuse or neglect of a resident has been identified.

Grounds / Motifs :

1. This Compliance Order (CO) was issued related to a severity level of level 3 (actual harm/risk), a scope of 3 (widespread) and a compliance history of 2 (previous unrelated non-compliance).

The licensee failed to protect residents from abuse by anyone.

For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, subject to subsection (2), a) the use of physical force by anyone other than a resident that caused injury or pain.

The home's policy "Prevention of Abuse and Neglect of a Resident", policy #VII-G_10.00 with a revised date of January 2015, stated that all residents had a right to dignity, respect and freedom from abuse and neglect. The Organization had a Zero Tolerance Policy for resident abuse or neglect. Abuse in that policy was defined as "Abuse of a resident by anyone that resulted in harm or a risk of harm to the resident."

1) On an identified date in August 2017 resident #003 reported to RPN #102 that a staff member was rough and caused altered skin integrity.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record of resident #003. The clinical record included a full assessment, completion of an incident report and initial assessments of the altered skin integrity and weekly thereafter until healed.

The Director of Care provided the home's internal investigative notes and findings to the LTCH Inspector. The home concluded that PSW #100 had used physical force toward resident #003 and the home took action.

During an interview with the LTCH Inspector and the Administrator, the Administrator acknowledged this incident met the definition of physical abuse.

2) On an identified date in February 2018, resident #002 reported to RPN #102 that a staff member came into the resident's room and was rough with the resident and yelled at them.

The Long-Term Care Homes (LTCH) Inspector interviewed the resident who confirmed the event.

During an interview with the DOC and the Administrator, they acknowledged the described incident did meet the definition of physical abuse.

3) On an identified date in February 2018, resident #001 was found to have responsive behaviours during the provision of care.

The LTCH Inspector interviewed the resident who described and demonstrated staff actions to them and showed them the injury as a result of the action.

The LTCH Inspector reviewed the written plan of care which directed staff what strategies and interventions to implement when a responsive behaviour occurred.

During the incident, staff noted an injury to the resident and RN #106 assessed the injury which required care.

During an interview with the Administrator by the LTCH Inspector, the Administrator acknowledged that staff actions resulted in an injury, constituted physical abuse. [s. 19. (1)]
(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 07, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_482640_0018, CO #001;

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 LTCHA.

Specifically the licensee must:

1) Ensure that direct care staff implement the strategies and interventions developed for resident #001's responsive behaviours.
2) Re-assess resident #020 regarding their responsive behaviours as per Compliance Order #001 from inspection #2017_482640_0018 served on November 17, 2017, and update the plan of care accordingly.

Grounds / Motifs :

1. 1. This Compliance Order (CO) was issued related to a severity level of level 3 (actual harm/risk), a scope of 1 (isolated) and a compliance history of 4 (ongoing non-compliance despite previous action taken by the Ministry).

The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to those behaviours.

1) On an identified date in February 2018, staff found resident #001 to have responsive behaviours during care.

The written plan of care dated February 2018, directed staff on strategies and interventions to implement when the resident demonstrated responsive behaviours.

During the review of the clinical records, the Long-Term Care Homes (LTCH) Inspector noted that two staff members did not implement the strategies or interventions for the resident.

During the incident, staff noted the resident had an injury and RN #106 assessed the altered skin integrity and noted it required care.

The home's policy "Responsive Behaviours-Management", policy #VII-F-10.20 with a revised date of October 2016, directed PSW staff to intervene using Gentle Persuasive Approach (GPA) techniques when they notice a change in a resident's behaviour.

PSW #100 informed the LTCH Inspector the plan of care directed staff on strategies and interventions to implement when the resident exhibited responsive behaviours and they had not implemented them at the time. They had not tried any other interventions.

2) On an identified date in February 2018, resident #001 was found to be exhibiting responsive behaviours.

The LTCH Inspector reviewed the clinical record and found the documentation did not include that interventions as per the plan of care were implemented for this situation.

The home's policy "Responsive Behaviours-Management", policy #VII-F-10.20 with a revised date of October 2016, directed staff to intervene using Gentle Persuasive Approach (GPA) techniques when they notice a change in a resident's behaviour.

During an interview with RN #106, they told the LTCH Inspector they had not tried any interventions related to this situation except for talking to the resident.

The RN confirmed they had not reviewed the written plan of care related to the interventions specific for the resident's responsive behaviours.

The licensee failed to ensure that strategies that were developed were implemented to respond to resident #001's behaviours. [s. 53. (4) (b)]

3. The licensee failed to ensure that for each resident demonstrating 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.

The licensee has failed to comply with compliance order (CO) #001from inspection #2017_482640_0018 served on November 17, 2017, with a compliance date of December 29, 2017.

The licensee was ordered to:

1. Ensure that resident #018 and resident #020 are reassessed regarding their responsive behaviours, including behavioural triggers, where possible.
2. Ensure that for each resident demonstrating responsive behaviours, including resident #018 and resident #020, strategies are developed and implemented to respond to these behaviours, where possible.

The licensee must be compliant with O.Reg.79/10, s. 53(4) (c).

The licensee completed steps #1 and #2 for resident #018 and step #2 for resident #020.
In step #1 for resident #20, the licensee was required to reassess the resident.
The licensee failed to ensure the requirement of the order was met.

During the course of the inspection the Long-Term Care Homes (LTCH) Inspector reviewed the clinical record for the resident #020. The clinical record did not include a re-assessment of this resident from the date the Compliance Order was served up to and including March 20, 2018.

During an interview with RPN #107, they confirmed there were no re-assessments of resident #020 during the time frame above. The last known assessment was that of August 10, 2017, during a visit to an external organization.

The LTCH Inspector interviewed the Director of Care (DOC) who was not able to identify any re-assessments of resident #020 during the specific time frame as above. The DOC acknowledged the home had not complied with CO #001 to reassess resident #020.

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2.
(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 04, 2018

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
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 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 10th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : Heather Preston

Service Area Office /
Bureau régional de services : Central West Service Area Office