Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 22, 23, 24, 25, 26, 29, Sep 22, 2011	2011_070141_0022	Critical Incident

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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, Registered Practical Nurses, Personal Support Workers, Environmental Supervisor, and Ontario Provincial Police
Richard Hayden LTC Inspector #127 attended the home on August 23, 2011.

During the course of the inspection, the inspector(s) Reviewed resident's records, home's 24-hour reports, internal incident reports, and the home's policy and procedures for pain and responsive behaviours.

The following Inspection Protocols were used during this inspection:

Medication

Pain

Personal Support Services

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16.

Findings/Faits saillants :

1. Outdoor windows were not restricted to 15 centimetres opening on the right side of the window in an identified resident's room. It was observed that both windows in the identified room were fully opened in 2011 past the screws in place to restrict opening. It was identified during this inspection that if the window pane was not correctly in the track that the window could slide past the screw intended to restrict the opening of the window.
2. During this inspection it was identified that the left movable pane of glass of the large window in an identified room could be open fully (beyond 15 centimetres) due to the window screen having been removed from the right side of the same window. s.16

Additional Required Actions:

RW October 24/2011

CO # - 901 was served on the licensee. ~~CO # - 003 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that an identified resident was cared for in a manner consistent with their needs. The resident had ongoing responsive behaviours that put them at risk as well as other residents. The resident exhibited periods of agitation which required chemical restraining. The resident had a history of physical aggression towards other residents and staff. The resident did not have behaviour monitoring initiated, a referral to psychogeriatric team or assessment and reassessment of all behaviours by the interdisciplinary team. The plan of care did not identify all the behaviours exhibited and did not identify possible triggers or interventions to effect specific behaviours. s.3.(1)4

Additional Required Actions:

CO # - 001 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home is a safe and secure environment for its residents. The window glass panes were fully opened beyond 15 centimetres, in 2011 in a specific room, as confirmed by staff. It was observed that the glass window pane nearest the screen had one screw in the window track to prevent the window from opening beyond 15 centimetres but the screw could be bypassed if the window was not correctly in the track. It was confirmed by witnesses that the inside panes (next to the screen) of two windows in an identified room were fully open and off their track. s.5

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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

Findings/Faits saillants :

1. The written plan of care for an identified resident was not completely developed to meet their needs related to responsive behaviours. The resident had exhibited multiple responsive behaviours. These behaviours were not identified in the plan of care and there were no interventions identified to direct staff when caring for the resident.
There was no assessment or reassessment of these behaviours completed to identify possible triggers that may have resulted in the responsive behaviours. s.53.(1)1
2. The licensee did not ensure that an identified resident's needs were met related to their responsive behaviours through monitoring and internal reporting. The resident exhibited ongoing responsive behaviours that caused agitation and included physical aggression towards both residents and staff. The behaviours were not monitored following the home's procedure using a Resident Observation Record. Internal Reporting in the home including 24 Hour Report and Internal Incident Reports were not completed for incidents of exhibited behaviour. The quarterly Interdisciplinary Care Conference of July, 2011 did not identify exhibited responsive behaviours. The Resident Assessment Protocol (RAPs) for behavioural symptoms, for July, 2011, did not identify all the resident's risk of risk behaviours.
Screening protocols as per the home's policy "Residents with Behavioural and Psychological Symptoms of Dementia" (VII-F-10.04) were not completed for the resident. s.53(1)3
3. Strategies developed in the plan of care were not implemented to respond to an identified resident's exhibited responsive behaviours. The resident's plan of care stated initiation of behaviour charting to identify why the resident became angry or agitated noting the time of day, who was present and what proceeded the incident. There was no behavioural charting initiated. The Licensee's Policy and Procedure "Resident with Behavioural and Psychological Symptoms of Dementia" (VII-F-10.04) states residents displaying behaviours that deviate from their known behaviours should have a Resident Observation Record initiated in which to document resident's behaviours.
The resident had difficulty communicating with staff in the home. The plan of care gave direction to staff to aide in communicating in time of agitation to assist the resident. The resident frequently exhibited behaviour of verbal agitation. There was no evidence to identify that attempts were made to utilize the intervention identified on the plan of care at times of resident agitation to assist with the resident and identify possible triggers to the agitation. s.53(4)(b)
4. An identified resident was not referred to specialized resources when required. The resident had ongoing responsive behaviours since admission in 2010. The resident did not have a referral for a psychogeriatric consultation, related to the behaviours, completed. s.53(1)4

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee did not ensure that a written record was maintained and kept up to date at all times for an identified resident. The resident's progress notes at the time of an identified incident did not provide full details of an identified incident including time, location, witnesses, resident status preceding, and time of actions taken by staff and outside agencies. s.231.(b)

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 137. Restraining by administration of drug, etc., under common law duty

Specifically failed to comply with the following subsections:

s. 137. (2) Every licensee shall ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 36 of the Act is documented, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. Circumstances precipitating the administration of the drug.
2. Who made the order, what drug was administered, the dosage given, by what means the drug was administered, the time or times when the drug was administered and who administered the drug.
3. The resident's response to the drug.
4. All assessments, reassessments and monitoring of the resident.
5. Discussions with the resident or, where the resident is incapable, the resident's substitute decision-maker, following the administration of the drug to explain the reasons for the use of the drug. O. Reg. 79/10, s. 137 (2).

Findings/Faits saillants :

1. The licensee did not ensure that every administration of a drug to restrain an identified resident, when immediate action was necessary, was discussed with the resident's Power of Attorney (POA), following the administration of the drug, to explain reasons for the use of the drug. A medication for chemical restraint was administered as needed on multiple occasions in 2011 to the identified resident. The POA was not contacted on any of these occasions to discuss the reasons for the use of the drug. s.137.(2)5

Issued on this 24th day of October, 2011

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

Rebecca Lyle for Shailee McNally

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHARLEE MCNALLY (141)
Inspection No. / No de l'inspection :	2011_070141_0022
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Aug 22, 23, 24, 25, 26, 29, Sep 22, 2011
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 : 901 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16.

Order / Ordre :

1. The licensee of the long-term care home shall repair the large resident accessible window in an identified room to restrict the opening to 15 centimetres.
2. The licensee of the long-term care home shall install a screen in the large resident accessible window in an identified room

Grounds / Motifs :

1. Outdoor windows were not restricted to 15 centimetres and screened. In an identified room the left movable panes of the large window could be open fully (beyond 15 centimetres) due to the window screen having been removed from the right side of the same window. (141)

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

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Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to

be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee will prepare, submit and implement a plan for achieving compliance to ensure that all resident's in the home are care for in a manner consistent with their needs related to all responsive behaviours including those that may cause risk to the resident or others.
The plan is to be submitted by September 6, 2011 to LTC Inspector Sharlee McNally, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street East, 11th Floor, Hamilton, Ontario, L8P 4Y7, Fax 905-546-8255

Grounds / Motifs :

1. The licensee did not ensure that an identified resident was cared for in a manner consistent with their needs. The resident had ongoing responsive behaviours that put them at risk as well as other residents. The resident exhibited periods of agitation which required chemical restraining. The resident had a history of physical aggression towards other residents and staff. The resident did not have behaviour monitoring initiated, a referral to psychogeriatric team or assessment and reassessment of all behaviours by the interdisciplinary team. The plan of care did not identify all the behaviours exhibited and did not identify possible triggers or interventions to effect specific behaviours. s.3.(1)4 (141)

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

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee of the long-term care home will prepare, submit and implement a plan to ensure all windows in the home with access to the outside are maintained in safe and secure manner including restricting the opening by no more than 15 centimetres at all times.
The plan is to be submitted by September 6, 2011 to LTC Inspector Sharlee McNally, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, Fax 905-546-8255

Grounds / Motifs :

1. The licensee did not ensure that the home is a safe and secure environment for its residents. The window glass panes were fully opened beyond 15 centimetres in 2011 in a specified room, as confirmed by staff. It was observed that the glass window pane nearest the screen had one screw in the window track to prevent the window from opening beyond 15 centimetres but the screw could be bypassed if the window was not correctly in the track. It was confirmed by witnesses that the inside panes (next to the screen) of two windows in an identified room were fully open and off their track. s.5 (127) (141)

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

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16.

Order / Ordre :

Error

Grounds / Motifs :

1. Refer to Order #901 (141)

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

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Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure:
1. Resident's written approaches to care related to responsive behaviours include assessment and reassessment of all exhibited behaviours and to identify possible triggers.
2. Resident's responsive behaviours are monitored and reported through internal protocols.
3. Resident's with exhibited ongoing responsive behaviours are referred to to specialized resources.
The plan is to be submitted by September 6, 2011 to LTC Inspector Sharlee McNally, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, Fax 905-546-8255

Grounds / Motifs :

1. Strategies developed in the plan of care were not implemented to respond to an identified resident's exhibited responsive behaviours. The resident's plan of care stated initiation of behaviour charting to identify why the resident became angry or agitated noting the time of day, who was present and what proceeded the incident. There was no behavioural charting initiated. The Licensee's Policy and Procedure "Resident with Behavioural and Psychological Symptoms of Dementia" (VII-F-10.04) states residents displaying behaviours that deviate from their known behaviours should have a Resident Observation Record initiated in which to document resident's behaviours.
The resident had difficulty communicating with staff in the home. The plan of care gave direction to staff to aide in communication in times of agitation to assist the resident. The resident frequently exhibited behaviour of verbal agitation. There was no evidence to identify that attempts were made to utilize the interventions identified on the plan of care at times of resident agitation to assist with the resident and identify possible triggers to the agitation. s.53(4)(b) (141)
2. The licensee did not ensure that an identified resident's needs were met related to their responsive behaviours through monitoring and internal reporting. The resident exhibited ongoing responsive behaviours that caused agitation and included physical aggression towards both residents and staff. The behaviours were not monitored following the home's procedure using a Resident Observation Record. Internal Reporting in the home including 24 Hour Report and internal Incident Reports were not completed for incidents of exhibited behaviour. The quarterly Interdisciplinary Care Conference of July, 2011 did not identify exhibited responsive behaviours. The Resident Assessment Protocol (RAPs) for behavioural symptoms, for July, 2011, did not identify all the resident's risk of risk behaviours. s.53(1)3 (141)
3. The written plan of care for an identified resident was not completely developed to meet their needs related to responsive behaviours. The resident had exhibited multiple responsive behaviours. These behaviours were not identified in the plan of care and there were no interventions identified to direct staff when caring for the resident. s.53.(1)1 (141)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board

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

and the

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

Issued on this 14th day of September, 2011

Signature of Inspector / Signature de l'inspecteur : Rebecca Qin for Sharlee McNally

Name of Inspector / Nom de l'inspecteur : SHARLEE MCNALLY

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