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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 18, 2018	2018_742527_0009	023662-16, 023905-16, 030378-16, 033587-16, 035451-16, 000177-17, 001411-17, 010730-17, 011018-17, 011165-17, 015406-17, 015786-17, 017673-17, 001146-18, 003085-18, 005858-18, 008465-18	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L0L 1X0

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

Sunset Manor Home for Senior Citizens
49 Raglan Street COLLINGWOOD ON L9Y 4X1

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

KATHLEEN MILLAR (527), AMANDA COULTER (694)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 7, 8, 9, 14, 15, 16, 17

and 18, 2018.

The following Critical Incidents (CIS) were inspected:

Log #033587-16, related to alleged staff to resident abuse;
Log #030378-16, related to responsive behaviours;
Log #023905-16, related to alleged abuse of a resident;
Log #023662-16, related to responsive behaviours;
Log #035451-16, related to alleged neglect by staff;
Log #017673-17, related to responsive behaviours;
Log #015786-17, related to a fall;
Log #010730-17, related to a fall;
Log #011018-17, related to resident trapped under bed;
Log #001411-17, related to positioning;
Log #000177-17, related to alleged staff to resident abuse;
Log #015406-17, related to alleged staff to resident abuse;
Log #011165-17, related to transferring;
Log #005858-18, related to Acute Respiratory Outbreak;
Log #001146-18, related to Responsive Behaviours;
Log #008465-18, related to Acute Respiratory Outbreak; and
Log #003085-18, related to Missing Narcotic.

Onsite Inquiries were conducted concurrently, which included:

Log #026364-17, related to Responsive Behaviours;
Log #021877-17, related to a Fall; and
Log #001147-18, related to Responsive Behaviours.

The Complaint inspection #2018_742527_0012, log #026423-17, related to resident to resident abuse was conducted concurrently with the CIS inspections. Findings of non-compliance were identified with responsive behaviours and they have been incorporated into this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), the Associate Director of Care (ADRC) / Infection Prevention and Control (IPAC) Lead, registered nurses (RNs), registered practical nurses (RPNs), Personal Support Workers (PSWs), Responsive Behaviour Nurse, Program Support Services Manager and the Professional Standards

Supervisor.

During the course of this inspection, the inspector toured the home, reviewed the licensee's compliance plan, reviewed clinical records, reviewed the licensee's policies and procedures, interviewed staff and residents, and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

s. 53. (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 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; (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.

The Responsive Behaviour Program evaluation for 2016 was reviewed as the 2017 annual program evaluation would not be completed until July 2018. On the 2016 annual program evaluation there were no date(s) identified as it related to when the changes and improvements were implemented.

The home's policy titled "Responsive Behaviours", number NPC E-20, and effective

February 2011, directed staff to keep a written record of the evaluation and improvements.

The Supervisor, Professional Standards, Health and Emergency Services was interviewed in May 2018 and acknowledged that they were expected to identify the date (s) on the annual program evaluation and this was not done.

The licensee failed to ensure that the written record of the 2016 annual program evaluation included the date that the changes and improvements were implemented.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #001146-18.

2. The licensee failed to ensure that the behavioural triggers had been identified for the resident demonstrating responsive behaviours.

A) Resident #003 was exhibiting behaviours and early in 2018, the resident was observed by staff exhibiting behaviours towards resident #002.

Resident #003's clinical record was reviewed and there were no assessments completed to identify the behavioural triggers; however the clinical record indicated that the resident had a previous incident of inappropriate behaviours. There were no Physical, Intellectual, Emotional, Capabilities, Environmental and Social (P.I.E.C.E.S.) assessment completed on the clinical record, which would have assisted in identifying behavioural triggers. In addition, there was no Dementia Observation System (DOS) or Antecedent, Behaviour and Consequence (ABC) Charting, which was a behaviour log used for daily tracking of the resident's behaviours. The ABC Charting tool was an important tool, as indicated by the Responsive Behaviour Nurse in identifying patterns in behaviour and would also assist in determining the antecedent or trigger for this behaviour exhibited by the resident.

PSW #133 was interviewed and said that they report to the charge nurse if the resident had any new behaviours and that the PSWs and the charge nurse would tell them when to initiate DOS and ABC Charting. The PSW was not aware of the behavioural triggers for resident #003.

The Responsive Behaviour RPN #140 was interviewed and acknowledged that based on their decision tree for responsive behaviours and their practice, they would conduct a

P.I.E.C.E.S. assessment to assist the team to identify behavioural triggers and the staff would be expected to complete the DOS and ABC Charting and monitor new behaviours to determine the cause for the incident. The RPN also said that when new behaviours occurred that the resident would be discussed at 'High Risk Rounds' and they would review the incident, the triggers, the behavioural strategies to ensure they were effective and/or if new strategies needed to be implemented.

Based on review of the 'High Risk Rounds' meeting minutes, the only actions taken were to submit a Critical Incident to the MOHLTC as a behaviour incident and monitor the resident. The staff were unable to locate any information on the resident's clinical record or any discussions at High Risk Rounds related to the resident's behavioural triggers.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #001146-18.

B) Resident #032 had a history of behaviours. An incident of occurred in late 2017. Based on the critical incident system (CIS) submitted to the Director, resident #032 was observed by staff exhibiting behaviours towards resident #031.

The written plan of care identified that resident #032 was known to have behaviours towards other residents.There were no dates or identification of which residents the written plan of care was referring to, and there were no behavioural triggers identified. Based on the clinical record review, there were a number of other incidents by resident #032, including a previous altercation with resident #031.

Review of the home's investigation notes and high risk rounds weekly meeting minutes related to resident #031 and #032 was completed. The review revealed that on two specific dates in 2017, resident #032's behaviour escalated. That information was not included in resident #032's plan of care.

The LTCH Inspector interviewed PSW #102 and #126, separately and they indicated that resident #032 had exhibited specific behaviours towards other residents including resident #031. PSW #126 was not aware what the triggers were for resident #032.

RPN #107 was interviewed and they were not aware of the behavioural triggers for resident #032. The RPN shared that they felt that it was the other resident that may have been a trigger for resident #032's behaviours, but that was not identified as a trigger on the plan of care.

The home failed to ensure that behavioural triggers for resident #032 were identified to assist in managing the residents' responsive behaviours. (694)

C) Resident #015 was exhibiting behaviours and on a specific date in 2017, when the resident was being assisted with care by PSW #139 an incident occurred. Two PSWs attended to assist PSW #139 and the resident's behaviours escalated, resulting in the resident being injured.

Resident #015's clinical record was reviewed and there were no behavioural triggers identified. The RAI-MDS assessment indicated the resident had no behavioural symptoms. There was no Physical, Intellectual, Emotional, Capabilities, Environmental and Social (P.I.E.C.E.S.) assessment completed on the clinical record, which would have assisted in identifying behavioural triggers. In addition, there was no Dementia Observation System (DOS) or ABC Charting.

PSW #139 was interviewed and had cared for the resident at the time of the incident and was not aware of the triggers for resident #015 and said that the resident's behaviour had worsened.

RPN #122 was interviewed and acknowledged the resident had behaviours and was also not aware of the triggers.

The Responsive Behaviour RPN #140 was interviewed and acknowledged that based on their decision tree for responsive behaviours and their practice, they would usually conduct a P.I.E.C.E.S. assessment to assist the team to identify behavioural triggers and the staff would be expected to complete the DOS and ABC Charting to identify triggers and monitor new behaviours to determine the cause for the incident. The RPN also said that when new behaviours occurred that the resident would be discussed at 'High Risk Rounds' and they would review the incident, the triggers, the behavioural strategies to ensure they were effective and/or if new strategies needed to be implemented.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #011165-17.

The licensee failed to ensure the behavioural triggers for resident #003, #015 and #032, were identified for the residents when demonstrating responsive behaviours.

3. The licensee failed to ensure that, for each resident demonstrating responsive behaviours that, (b) strategies were developed and implemented to respond to these behaviours, where possible.

A) Resident #003 had a history of behaviours, which were exhibited on specific dates in 2016 and 2018 and were observed by staff.

The clinical record was reviewed and on the RAI-MDS assessment it indicated that there were no changes in the resident's behavioural symptoms; however it was documented that the resident's behaviours increased the possibility of an injury. Staff were expected to implement specific interventions as per the written plan of care. The written plan of care was reviewed and identified there were no strategies developed and implemented to respond to the resident #002's behaviours.

The licensee's policy titled "Responsive Behaviours", number NPC E-20, and effective February 2011, directed staff to update the care plan to reflect potential risks and support strategies that may be used, as well as adopt the strategies on the plan of care that respond to triggers and responsive behaviours and minimize the risk of altercations.

PSW #133 ad #134 were interviewed and they were aware of the incidents in 2016 and 2018. They were unable to provide any information related to the individual strategies that were developed and/or implemented to address the resident's behaviours towards other residents.

RN #130 was interviewed and was aware of the incident in 2018, and they were not able to identify any strategies that were developed and implemented to manage the resident's behaviours.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #001146-18.

B) Resident #015 had behaviours and on a specific date in June 2017, the resident's behaviours escalated when two PSWs attended to assist PSW #139 with care. This incident resulted in the resident being injured.

The clinical record was reviewed and on the RAI-MDS indicated that the resident had no behavioural symptoms; however it was documented in the clinical record that the resident was exhibiting specific behaviours. The written plan of care had no behavioural

strategies developed and implemented.

The licensee's policy titled "Responsive Behaviours", number NPC E-20, and effective February 2011, directed staff to update the care plan to reflect potential risks and support strategies that may be used, as well as adopt the strategies on the plan of care that respond to triggers and responsive behaviours and minimize the risk of altercations.

PSW #139 was interviewed and they were aware of the incident on a specific date in June 2017; however they said the resident definitely had responsive behaviours, but was not aware of the behavioural interventions.

RN #122 was interviewed and was not aware of the behavioural interventions to respond to the resident's responsive behaviours.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #011165-17.

The licensee failed to ensure that, for resident #003 and #015 who were demonstrating responsive behaviours that strategies were developed and implemented to respond to these behaviours, where possible.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, a 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; and for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Resident #015 was being assisted by one person for care. The resident was exhibiting behaviours and when two PSWs attended to assist PSW #139 with care, the resident's behaviour escalated. The two PSWs left the room and PSW #139 completed the task.

The resident's behaviour resulted in the resident being injured. The resident was transferred to the hospital for further treatment.

RN #130 was interviewed and identified the resident had behaviours and for the resident's safety they needed specific assistance.

RPN #122 was interviewed and acknowledged that the resident required specific assistance for care and safety. The RPN said that when PSW #139 reported the incident to them, they assessed the resident and was not aware that the PSWs provided the type of assistance required for transferring the resident.

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #010.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents

Resident #032 had a history of specific behaviours and resident #031 was cognitively impaired. An incident occurred towards resident #031 by resident #032 in late 2017.

Resident #032's clinical record was reviewed for period of several months between 2017 and 2018, which identified that resident #032 exhibited behaviours resulting in a number of other incidents towards resident #031. There was no identification on the written plan of care as to what procedures were developed or steps taken to minimize the risk of further altercations between these residents.

The RAI-MDS assessment for resident #032, identified the resident had unsettled relationships and the behavioural triggers and/or the interventions were not identified or communicated to direct care staff.

PSW #102 was interviewed and indicated that resident #032 exhibited specific responsive behaviours, but thought it was related to an infection, which was not identified in the resident's plan of care.

PSW #102 and #126 were interviewed and indicated that resident #032 had exhibited specific behaviours towards other residents including resident #031. Both PSWs #126 and #102 spoke about their familiarity with both residents and acknowledged the behaviours were not all noted on the Point of Care (POC) kardex. Both PSWs were not aware of the assessments completed for behaviours and the outcome of the RAI-MDS assessments.

RPN #107 was interviewed and they were aware of resident #032's behaviours. The RPN acknowledged that the information was not identified on the written plan of care.

The licensee failed to ensure that resident #031 and #032's plan of care addressed procedures that were developed and implemented to assist residents and staff who were at risk of harm as a result of a resident's behaviour and to minimize the risk of altercations between residents.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others, to be implemented voluntarily.

WN #4: 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 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.

The licensee's policy titled "Zero Tolerance of Abuse and Neglect", number ADM F-10, and effective April 2017, directed staff to make an immediate report to the Ministry of Health and Long Term Care (MOHLTC) Director where there was a reasonable suspicion of abuse of a resident by anyone.

A) Resident #003 had an allegation of abuse towards resident #002, which occurred early in 2018 and the licensee did not notify the Director immediately.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #001146-18.

B) Resident #004 had an allegation of abuse towards resident #006 in early 2018 and the licensee did not notify the Director immediately.

RN #130 was interviewed and acknowledged that they completed the critical incident form and submitted to the MOHLTC Director on a specific date early 2018, which was not immediately after being notified of the incident. The RN acknowledged that they were expected, according to their policy and procedure for mandatory reporting of abuse, to report immediately and this was not done.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #001146-18.

The licensee failed to ensure that their policy to promote zero tolerance of abuse and neglect of residents was complied with regarding mandatory reporting involving resident #003 and #004.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Reviewed the 2017 annual retraining related to the Residents' Bill of Rights; the licensee's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections.

The Director of Resident Care (DRC) was interviewed and acknowledged that they had retrained all staff in 2017.

The Supervisor, Professional Standards, Health and Emergency Services was also interviewed and acknowledged that they had did not complete the annual retraining of all of their staff.

The licensee failed to ensure that all staff received retraining annually related to the

Residents' Bill of Rights; the licensee's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #001146-18.

2. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 3. Behaviour management.

Reviewed the 2017 annual retraining related to the Responsive Behaviours Program.

The DRC was interviewed and acknowledged that not all staff who provide direct care to residents were trained.

The Supervisor, Professional Standards, Health and Emergency Services was also interviewed and acknowledged that they had completed the annual retraining of all their direct care staff.

The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in Behaviour management.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #001146-18.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that, e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

The Prevention of Abuse and Neglect 2017 annual program evaluation was reviewed and there were no date(s) identified as it related to when the changes and improvements were implemented.

The licensee's policy titled "Zero Tolerance of Abuse and Neglect", number ADM F-10, and effective April 2015, directed the staff to keep a written record of each evaluation, which included the date(s) the changes were implemented.

The DRC and the Supervisor, Professional Standards, Health and Emergency Services were interviewed and acknowledged that they were expected to identify the date(s) on the annual program evaluation, when the prevention of abuse & neglect changes / improvements were implemented and this was not done.

The licensee failed to ensure that the written record of the 2017 annual program evaluation included the date that the changes and improvements were implemented.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall, (b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

A) Resident #033 had an unwitnessed fall in their room in 2017, which resulted in a change in condition and additional assistance with activities of daily living. The resident was subsequently transferred to the hospital for assessment.

The clinical record was reviewed and revealed that after the resident returned from the hospital, their condition worsened and the resident was transferred back to the hospital for reassessment, which resulted in the resident's admission to the hospital.

The licensee reported the incident to the Director on a specific date in July 2017, and submitted the critical incident via the Critical Incident System (CIS); however the Director was not notified until approximately five days when the resident had a significant change

in their health condition.

RPN #122 and PSW #123 were interviewed and were unable to recall the incident and/or the resident.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #015786-17.

B) Resident #006 had a fall on a specific date and time in May 2017 and was transferred to the hospital for further treatment.

The clinical record was reviewed, which identified that the home was notified by the resident's family that the resident had a significant change in their health condition.

The licensee did not report the incident to the Director until approximately four days after the resident's fall.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #010730-17.

The licensee failed to ensure that the Director was notified no later than three business days after the occurrence of the incident, when the injury resulted in a significant change in resident #006 and #033's health condition.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents: 1. Falls prevention and management.

The home's policy titled "Fall Prevention Policy", number NPC E-25, and effective date on April 2016, identified that education would be offered annually to all front line staff and records of this education would be kept as part of the annual education program.

The licensee's education records were reviewed and the home did not train all of their direct care staff related to the Falls Prevention and Management Program.

The DRC and the Manager for Professional Standards was interviewed and they acknowledged that not all direct staff were trained in 2017 related to their Falls Prevention and Management Program.

The licensee failed to ensure that all staff who provide direct care to residents received their 2017 annual training in Falls prevention and management.

Issued on this 31st day of July, 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) :	KATHLEEN MILLAR (527), AMANDA COULTER (694)
Inspection No. / No de l'inspection :	2018_742527_0009
Log No. / No de registre :	023662-16, 023905-16, 030378-16, 033587-16, 035451-16, 000177-17, 001411-17, 010730-17, 011018-17, 011165-17, 015406-17, 015786-17, 017673-17, 001146-18, 003085-18, 005858-18, 008465-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 18, 2018
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L0L-1X0
LTC Home / Foyer de SLD :	Sunset Manor Home for Senior Citizens 49 Raglan Street, COLLINGWOOD, ON, L9Y-4X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Sinclair

To Corporation of the County of Simcoe, 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 :

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) (a) of the LTCHA.

Specifically the licensee must:

a) Ensure residents #003, #015 and #032, have behavioural triggers identified.

b) Ensure residents #003, #015 and #032's responsive behaviour plan of care identify the residents' responsive behaviour triggers.

Grounds / Motifs :

1. The licensee failed to ensure that the behavioural triggers had been identified for the resident demonstrating responsive behaviours.

A) Resident #003 was exhibiting behaviours and early in 2018, the resident was observed by staff exhibiting behaviours towards resident #002.

Resident #003's clinical record was reviewed and there were no assessments completed to identify the behavioural triggers; however the clinical record indicated that the resident had a previous incident of inappropriate behaviours. There were no Physical, Intellectual, Emotional, Capabilities, Environmental and Social (P.I.E.C.E.S.) assessment completed on the clinical record, which would have assisted in identifying behavioural triggers. In addition, there was no

Dementia Observation System (DOS) or Antecedent, Behaviour and Consequence (ABC) Charting, which was a behaviour log used for daily tracking of the resident's behaviours. The ABC Charting tool was an important tool, as indicated by the Responsive Behaviour Nurse in identifying patterns in behaviour and would also assist in determining the antecedent or trigger for this behaviour exhibited by the resident.

PSW #133 was interviewed and said that they report to the charge nurse if the resident had any new behaviours and that the PSWs and the charge nurse would tell them when to initiate DOS and ABC Charting. The PSW was not aware of the behavioural triggers for resident #003.

The Responsive Behaviour RPN #140 was interviewed and acknowledged that based on their decision tree for responsive behaviours and their practice, they would conduct a P.I.E.C.E.S. assessment to assist the team to identify behavioural triggers and the staff would be expected to complete the DOS and ABC Charting and monitor new behaviours to determine the cause for the incident. The RPN also said that when new behaviours occurred that the resident would be discussed at 'High Risk Rounds' and they would review the incident, the triggers, the behavioural strategies to ensure they were effective and/or if new strategies needed to be implemented.

Based on review of the 'High Risk Rounds' meeting minutes, the only actions taken were to submit a Critical Incident to the MOHLTC as a behaviour incident and monitor the resident. The staff were unable to locate any information on the resident's clinical record or any discussions at High Risk Rounds related to the resident's behavioural triggers.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #001146-18.

B) Resident #032 had a history of behaviours. An incident of occurred in late 2017. Based on the critical incident system (CIS) submitted to the Director, resident #032 was observed by staff exhibiting behaviours towards resident #031.

The written plan of care identified that resident #032 was known to have behaviours towards other residents.There were no dates or identification of which residents the written plan of care was referring to, and there were no

behavioural triggers identified. Based on the clinical record review, there were a number of other incidents by resident #032, including a previous altercation with resident #031.

Review of the home's investigation notes and high risk rounds weekly meeting minutes related to resident #031 and #032 was completed. The review revealed that on two specific dates in 2017, resident #032's behaviour escalated. That information was not included in resident #032's plan of care.

The LTCH Inspector interviewed PSW #102 and #126, separately and they indicated that resident #032 had exhibited specific behaviours towards other residents including resident #031. PSW #126 was not aware what the triggers were for resident #032.

RPN #107 was interviewed and they were not aware of the behavioural triggers for resident #032. The RPN shared that they felt that it was the other resident that may have been a trigger for resident #032's behaviours, but that was not identified as a trigger on the plan of care.

The home failed to ensure that behavioural triggers for resident #032 were identified to assist in managing the residents' responsive behaviours. (694)

C) Resident #015 was exhibiting behaviours and on a specific date in 2017, when the resident was being assisted with care by PSW #139 an incident occurred. Two PSWs attended to assist PSW #139 and the resident's behaviours escalated, resulting in the resident being injured.

Resident #015's clinical record was reviewed and there were no behavioural triggers identified. The RAI-MDS assessment indicated the resident had no behavioural symptoms. There was no Physical, Intellectual, Emotional, Capabilities, Environmental and Social (P.I.E.C.E.S.) assessment completed on the clinical record, which would have assisted in identifying behavioural triggers. In addition, there was no Dementia Observation System (DOS) or ABC Charting.

PSW #139 was interviewed and had cared for the resident at the time of the incident and was not aware of the triggers for resident #015 and said that the resident's behaviour had worsened.

RPN #122 was interviewed and acknowledged the resident had behaviours and was also not aware of the triggers.

The Responsive Behaviour RPN #140 was interviewed and acknowledged that based on their decision tree for responsive behaviours and their practice, they would usually conduct a P.I.E.C.E.S. assessment to assist the team to identify behavioural triggers and the staff would be expected to complete the DOS and ABC Charting to identify triggers and monitor new behaviours to determine the cause for the incident. The RPN also said that when new behaviours occurred that the resident would be discussed at 'High Risk Rounds' and they would review the incident, the triggers, the behavioural strategies to ensure they were effective and/or if new strategies needed to be implemented.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection log #011165-17.

The licensee failed to ensure the behavioural triggers for resident #003, #015 and #032, were identified for the residents when demonstrating responsive behaviours.

2. The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 4 compliance history of on-going non-compliance with this section of the Act that included:
- Voluntary plan of correction (VPC) issued July 5 2016 (2016_251512_0011).

(527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 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 18th day of July, 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 : Kathleen Millar

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