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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 10, 2013	2013_205129_0004	H-000049-13/H-001834-12	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF SANDALWOOD PARK
425 Great Lakes Drive, BRAMPTON, ON, L6R-2W8

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 3, 5, 8, 15, 16, 17, 18, 22, May 6, 7, 8, June 21 and 25, 2013

This inspection included 1 complaint inspection related to pain and unexplained fractures (Log #H-001834-12 and 1 complaint related to positioning, resident's rights, foot care and nutritional care (Log # H-000049-13).
A critical incident inspection (#2013_205129_0003) was conducted concurrently with this complaint inspection and included 2 critical incidents related to inappropriate care for four residents(Log # H-000175-13 and one critical incident related to abuse (Log #H-000164-13)
Areas of non compliance identified during the critical incident inspection are included in this report.

During the course of the inspection, the inspector(s) spoke with residents and resident's substitute decision makers, regulated and unregulated nursing staff, Registered Dietitian, Director of Care and the General Manager in relation to log #H-000049-13 and #H-001834-12

During the course of the inspection, the inspector(s) observed residents, reviewed clinical documentation, staffing schedules and reviewed the Behavioural Program Framework policy, the Responsive Behaviour/Aggression Prevention policy,the Pain Management policy, the Consent to Treatment policy, the Antipsychotropic Medication policy, the Resident Abuse policy the Mandatory Reporting policy and the home's Pain Management Program.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Nutrition and Hydration

Pain

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the right of the residents to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity was fully respected and promoted for resident #002, resident #004, resident #005 and resident #006, in relation to the following: [3(1)1]
a) Resident #002 was not treated with courtesy and respect when this resident when staff did not attempt to assist this resident from the floor for an extended period of time. The plan of care for this resident indicated that the resident had a history of falls, was at risk for falling, had an unsteady gait and poor balance, was having difficulty adjusting to the environment and required the assistance of staff to transfer. Video surveillance taken by the home on an identified date showed this resident was awake, wandering in the halls and was noted to enter the nursing station area at 0140hrs. A staff person was noted to attempt to push the resident out of the nursing station area while the resident was sitting in an office chair at 0154hrs. This action was not successful in moving the resident from the nursing station area and five minutes later a second staff person entered the nursing station area and a staff person was noted to pull on the back of the resident's belt in an attempt to pull the resident backwards out of the nursing station while the resident was standing. While the staff person was pulling the resident backwards into the hallway the resident appeared to fall to the floor. The video showed one staff person returning to the nursing station area and the second staff person returned to the lounge area across from the nursing station. The resident was then noted to struggle unsuccessfully to get up from the floor for 25 minutes after which the resident stopped struggling and was noted to just lay down on the floor. The resident remained on the floor for 25 more minutes and although staff were in close proximity to the resident the resident was not monitored for safety nor did staff attempt to assist the resident to rise off the floor. The General Manager confirmed the events that were captured by video surveillance.
(PLEASE NOTE: This evidence of non-compliance was found during inspection #2013_205129_0003)

b) Resident #004 was not treated with courtesy and respect when this resident was provoked into a behavioural response by staff during the evening meal on an identified date. The plan of care for this resident identified that the resident demonstrated many responsive behaviours and included information for staff about how to successfully interact with this resident in order meet the resident's needs. Video surveillance taken by the home on an identified date in the dining room showed this resident responding to a conversation that two other residents were having by saying "you go to hell", a staff person who was noted to be sitting at another table a

distance away from resident #004 responded to resident by saying " no you go to hell". The resident responded to the comment from the staff person and then the staff person responded by saying to the resident "no you and your dog go to hell" and "you are stupid and your daughter is stupid". The General Manager confirmed the verbal responses made to this resident and captured on the video surveillance.
(PLEASE NOTE: This evidence of non- compliance was found during inspection #2013_205129_0003)

c) Resident # 005 was not treated with courtesy and respect when staff did not allow the resident to maintain independence in eating and forced the resident to drink. The plan of care for this resident indicated that the resident required some encouragement and cuing to eat, staff were to guide the resident's hand if necessary while eating, staff were directed to allow the resident to participate in activities of daily living to the fullest extent possible and the Registered Dietitian had assessed the resident as a safety risk while eating and placed the resident on a textured modified diet. Video surveillance taken by the home during the evening meal on an identified date showed a staff person sitting beside the resident at the dining table, putting a glass of fluid to the resident's mouth, and the resident is seen to push the staff person's hand away. The staff person was then noted to hold both the resident's hands down and again was seen to bring the glass to the resident's mouth. It was noted that on the first attempt by the staff person to have the resident drink, the resident turned her head away; however the staff person then followed the resident's mouth with the glass forcing the resident to drink. It was noted that the staff person appeared to not give the resident sufficient time to swallow before again moving the glass to the resident's lips and forcing the resident to drink. The General Manager confirmed the events as described above and also confirmed that the staff person did not give the resident sufficient time to swallow the fluid before forcing the resident to drink more.
(PLEASE NOTE: This evidence of non- compliance was found during inspection #2013_205129_0003)

d) Resident #006 was not treated with dignity and respect when this resident was provoked into a behavioural response by staff. The plan of care for this resident indicated that responsive behaviours demonstrated by the resident increased when the resident was over stimulated, when over stimulated the resident will frequently become agitated, scream and call people names and staff were not to allow unpleasant surprise situations such as sudden approaches from behind. Video surveillance taken by the home during the evening meal on an identified date

indicated the resident was sitting quietly at a table with three other residents waiting for the meal service to begin, a staff person was noted to walk behind the resident, suddenly appear on the resident's left side and push the resident's left arm and shoulder while saying "what's wrong with you". The resident did not respond to the staff person and did not engage the staff person in conversation. The staff person is again noted to push the resident's arm saying "hey you, hey you", at which point the resident started screaming, became upset and began yelling "I hate you, I hate you, I hate you" to the staff person. The General Manager confirmed the events captured on the video surveillance and indicated that the staff person involved in this incident knows the resident's needs and issues and would have been aware that their actions would likely provoke a behavioural response from this resident.
(PLEASE NOTE: This evidence of non- compliance was found during inspection #2013_205129_0003) [s. 3. (1) 1.]

2. The licensee did not ensure that resident #001 and resident #007's right to be protected from abuse was fully respected and promoted, in relation to the following: [3 (1)2]
a) Resident #001 was physically abused which resulted in the resident receiving injuries to both hands while care was being providing on an identified date. On this date two students providing care to the resident asked a staff member for assistance in providing care and then reported to their clinical instructor and the home that the staff member entered the room, instructed the resident it was time for care, at which time the resident declined; however, the staff member continued to roughly turn the resident in bed and proceeded with care despite the resident asking the staff person to stop. It was reported that the resident tried to stop the staff member from providing personal care and in response the staff member grabbed the resident's hand and twisted the resident's fingers. Staff and the clinical records documented the injuries sustained by the resident. During an interpreted interview at the time of this inspection the resident indicated that she did not currently have pain, she is frightened, she was concerned that people would gossip about this incident and that she has not seen the person who caused these injuries since the incident occurred. Written statements obtained during the homes investigation of this incident as well as a Critical Incident Report submitted to the Ministry of Health and Long Term Care confirmed the above noted facts.
(PLEASE NOTE: This evidence of non- compliance was found during inspection #2013_205129_0003)

b) Resident #007 was physically abused, suffered an injury while care was being provided on an identified date and suffered a second injury of the same limb a year later. The plan of care for this resident indicated the resident had a medical condition which resulted in the resident not being able to independently move the left arm and leg, a medical condition that resulted in fragile bones, the resident was not independently ambulatory, had challenges communicating and demonstrated resistance to care.

Daily documentation in the clinical record for four months prior to the first injury indicated the resident was resistive to care and aggressive while care is being provided. The care plan directed that two or three staff members were required to provide care and that one staff member was to provide care while the other staff members were to hold the resident's right arm and leg due to aggressive behaviours. Documentation in the clinical record indicated that the resident often resisted care by scratching, kicking, swearing and spitting at staff.

-On the identified date it was documented in the clinical record that the resident was resisting care, however, despite this a registered staff and unregulated staff provided care to the resident at 1600hrs. While this care was being provided staff reported and it is documented that the resident attempted to kick staff but did not make contact with either staff or an object and the staff present in the room heard a sound that would indicate the resident had suffered an injury. Documentation indicated that the physician was contacted and the resident was ordered to have an x-ray. The resident was monitored at 1830hrs and staff noted the resident began to demonstrate signs that an injury had been sustained including visual changes and pain. Throughout the course of the next day staff documented that the resident continued to be in pain when touched, the area remained swollen and medication was administered to manage pain. A diagnostic procedure confirmed the resident had sustained a fracture.

- On an identified date in 2012 documentation in the clinical record continued to indicate that on a daily basis this resident demonstrated resistance to care and staff continued to provide care despite the resident resistance. Directions for staff continued to be that two staff were to provide care to the resident due to the resistive behaviour and one staff member was to hold the resident's right arm and leg during care to prevent injury to staff. On an identified date it was documented that the resident began to demonstrates signs of an injury which included visual changes and pain. Staff contacted the resident's physician who order the resident transferred to hospital for assessment of the injury. The resident returned to the home after being treated in hospital for a fracture. Staff confirmed that due to the resident's mobility

limitations it would not have been possible for these injuries to be the result of resident independent action and also confirmed that forcing a resident to receive care while demonstrating resistive behaviours was considered abuse. [s. 3. (1) 2.]

3. The licensee did not ensure that resident #007's right to be properly cared for in a manner consistent with the resident's identified needs was fully respected and promoted, in relation to the following: [3(1)4]
Resident #007 suffered an injury on or before an identified date in 2012; however the resident was not assessed nor was this injury treated for at least two days after the symptoms were noted. There was no documentation in the clinical record that would indicate staff assessed this injury or whether or not the resident was experiencing pain as a result of this injury. The resident was transferred to the hospital for assessment and treatment of this injury two days following the identification of symptoms and returned to the home with a diagnosis of a fracture. This resident suffered a similar injury to the in 2011 and clinical documentation indicated the resident presented with the same type of symptoms, however staff did not take action to assess, monitor or alter care when this resident presented with the same symptoms prior to September 9, 2012. [s. 3. (1) 4.]

4. The licensee did not ensure that resident #003 and resident #008's right to participate fully in the development, implementation, review and revision of their plan of care was fully respected and promoted, in relation to the following: [3(1)11i]
a) Resident #003 was not given an opportunity to participate in the annual review of the care and services being planned or provided in relation to the resident's identified needs. Clinical record documents indicated that the resident had not attended four care conferences that were held over the last three years. Staff confirmed that although the resident demonstrated and understanding of care issues the resident had not been invited to attend these care meetings.
b) Resident #008 was not given an opportunity to participate in the annual review of care and services being planned or provided in relation to identified needs. Clinical record documents indicated that the resident had not attended four annual care conferences that were held over the last four years. Staff confirmed that although the resident demonstrated an understanding of care issues the resident had not been invited to attend these care meetings. [s. 3. (1) 11. i.]

5. The licensee did not ensure that resident #003 and resident #008's right to give or refuse consent to any treatment, care or services for which consent is required was

fully respected and promoted, in relation to the following: [3(1)11ii]
a) Resident #003 was not provided with the opportunity to give or withhold consent for care and treatments being proposed and provided, despite the resident demonstrating decision making abilities and medical option that the resident had good cognition. Clinical record documentation indicated that the resident's substitute decision maker (SDM) consented to the resident receiving influenza vaccinations, made decisions regarding advanced care directions, made decisions regarding whether to bathe or shower and the number of days in the week this care would be provided, consented for Physiotherapy assessment and treatment, consented for the use of bed rails as a restraint, consented for dental screening and signed a release of responsibility form with respect to diet texture. The 2012 annual physical completed by the resident's physician indicated that the resident had good cognition and staff providing recreational programming for this resident indicated they have no concerns with respect to the resident making decisions regarding recreational and social program attendance. The resident indicated that she felt she was able to make decisions for herself and at the time of this inspection demonstrated decision making skills with respect to weight management, prevention of skin breakdown as well as treatments such as influenza vaccinations. Staff confirmed that when the clinical record contains the name of a SDM, they would not seek the resident's consent for care and treatment.
b) Resident #008 was not provided with the opportunity to give or withhold consent for care and treatments being proposed and provided, despite not having a medical diagnosis that would affect the resident's cognitive abilities and the resident demonstrating decision making skills. Clinical record documentation indicated that the resident's SDM consented to a physiotherapy consultation, made decisions regarding whether to bathe or shower and the number of times this care would be provided in a week, made decisions regarding advanced care directions, consented to vaccinations, consented to additional services to be provided to the resident and consented to dental screening. The resident indicated she felt she was able to make decisions for herself and at the time of this inspection demonstrated and understanding of care required for activities of daily living and was able to converse appropriately about events of the day. . Staff confirmed that when the clinical record contains the name of a SDM, they would not seek the resident's consent for care and treatment. [s. 3. (1) 11. ii.]

Additional Required Actions:

CO # - 001, 002, 003, 004 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 and ensuring that the right to be properly cared for in a manner consistent with their needs is fully respected and promoted for all residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that staff and others involved in different aspects of the care for resident #007 collaborated with each other in the assessment of pain being experienced by this resident, and in the development and implementation of the plan of care in relation to the following: [6(4)(a)(b)]
Resident #007 was assessed by the Physiotherapist as having chronic pain in an identified area and at the time put in place a treatment to manage this pain.
Nursing staff assessed this resident as having chest pain from angina, joint pain from arthritis, pain from two fractures (occurred in 2011 and 2012) and indicated the resident complained of pain related to general body ache, arm and leg and headaches for which the resident was receiving a regularly scheduled non- narcotic analgesic Nursing staff and clinical documentation confirmed that nursing staff and physiotherapy staff did not discuss their individual assessments of the pain the resident was experiencing nor did they work together to establish and implement a plan of care that ensured the pain the resident was experiencing was being monitored and managed. Clinical documentation indicated the resident continued to experience pain. [s. 6. (4)]

2. The licensee did not ensure that the care set out in the plan of care was provided to residents as specified in the plan, in relation to the following: [6(7)]
a) Staff did not provide care as set out in resident #001's plan of care when it was reported that a nursing staff member providing care continued to provide care to the resident despite the resident becoming agitated and resisting care. Staff and clinical documentation confirmed that an identified concern in the resident's plan of care was that the resident demonstrated anger towards staff, and resistive behaviours. Interventions in place to address this area of concern included directions for staff to use a calm, gentle, matter of fact approach with the resident and if the staff person's presence began to agitate the resident staff were to leave the resident and have another staff person assist the resident. This care was not provided on the above noted situation and the resident sustained an injury while resisting the provision of care.
(PLEASE NOTE: This evidence of non- compliance was found during inspection #2013_205129_0003)

b) Staff did not provide care as set out in resident #004's plan of care when on an identified date video surveillance identified a staff member making negative comments to the resident about the resident's daughter and the resident's former pet that resulted in the resident demonstrating a negative responsive behaviour in the

presences of others. Staff and clinical documentation confirmed that a care goal identified in the resident's plan of care was for the resident to have reduced episodes exhibiting responsive behaviours. Interventions put in place to meet this goal included directions that staff were to avoid arguing with the resident and staff were not to discuss the resident's former pet as this may trigger a behavioural response. On the above identified date this care was not provided and the resident exhibited a negative responsive behaviour.
(PLEASE NOTE: This evidence of non-compliance was found during inspection #2013_205129_0003)

c) Staff did not provide care as set out in resident #005's plan of care when on an identified date video surveillance identified a staff member who did not allow the resident to be independent in eating and drinking and was seen to force the resident to drink. Staff and clinical documentation confirmed that care goals identified in the resident's plan of care were for the resident to participate in activities of daily living (ADLs) and for the resident to maintain functional abilities to the best possible extent. Interventions put in place to meet these goals included directions to staff that the resident was to be allow to participate in ADL's, the resident may require reminders to eat, staff were to provide encouragement and cuing at meals, staff were to encourage the resident to sit at the dining table and complete the meal and the resident may sometimes require staff to guide the resident's hand to her mouth when eating. On the above noted date, this care was not provided and the resident was prevented from being able to function independently when eating.
(PLEASE NOTE: This evidence of non-compliance was found during inspection #2013_205129_0003)

d) Staff did not provide care as set out in resident #006's plan of care when on an identified date video surveillance identified a staff member taking action that resulted in the resident demonstrating a negative responsive behaviour in the presence of others. Staff and clinical documentation confirmed that a care goal identified in the resident's plan of care was for the resident to be able to engage in meaningful interactions with others. Interventions put in place to meet this goal included directions to staff to not allow unpleasant surprise situations such as sudden approaches and staff were to ensure quiet surroundings with minimal distractions. On the above noted date this care was not provided and staff engaged the resident in a negative interaction while in the presence of others.
(PLEASE NOTE: This evidence of non- compliance was found during inspection

#2013_205129_0003)

e)Staff did not provide care as set out in resident #007's plan of care when documentation in the clinical record indicated that staff provided care to the resident, despite the resident resisting this care. Staff and clinical documentation confirmed that the resident's plan of care identified a care concern related to the resident demonstrating inappropriate responses as well as aggressiveness and resistive to care behaviours. The goal of care related to this concern was that the resident would have reduced episodes of demonstrating these behaviours and interventions put in place to meet this goal included directions to staff that when the resident is aggressive when approached for care staff were to leave the resident and retry again at a later time when the resident appeared to be in a better mood and that if the strategies were not working staff were to leave the resident and return in five to ten minutes and attempt to provide care. According to documentation in the clinical record this care was not provided to the resident over an extended period of time and the resident was injured twice while staff were providing care. [s. 6. (7)]

3. The licensee did not ensure that the residents were reassess and the plan of care reviewed and revised when the care needs of the resident change, in relation to the following: [6(10)b]
a) Staff #101 confirmed that on an identified date after believing resident #007 had sustained an injury during the provision of care she did not return to reassess the resident in order to determine the type or degree of injury the resident had received and she did not review or revise the plan of care based on the changing needs of this resident. Staff #101 and clinical documentation confirmed that the identified staff and a PSW were in the resident's room attempting to provide care, when resident#007 kicked out at the PSW, following which this staff person heard a sound that would indicate the resident had sustained an injury. This staff person acknowledged that she suspected that the resident had sustained an injury when she documented that both staff stopped what they were doing and left the resident. Clinical documentation recorded by this staff person indicated that she contacted the resident's physician, provided details of the incident and in response the resident's physician order the resident to receive an X-ray. Staff #101 confirmed that she attended the resident two hours after the incident and provided Tylenol for pain but did not assess the resident's injured limb and did not alter the plan of care based on a suspicion that the resident had sustained a fractured. X-ray results confirmed that resident #007 had sustained a fracture. [s. 6. (10) (b)]

4. The licensee did not ensure that residents were reassessed and the plan of care reviewed and revised at any time when the care set out in the plan of care has not been successful, in relation to the following: [6(10)(c)
a) Resident #007's plan of care indicated that a goal of care was to reduce episodes of exhibiting behaviour, however this resident was not reassessed nor was the plan of care reviewed or revised when it was identified that the care being provided to the resident had not been effective in reducing episodes of identified responsive behaviours.
-Data collected during a Minimum Data Set (MDS) review completed in May 2012 indicated that there had been no change in the resident's behavioural status over the previous three months and the resident continued to demonstrate four identified responsive behaviours on a daily or almost daily basis. An assessment protocol note recorded in the clinical record in June 2012 indicated that the plan was to review the care plan with the goal to decrease episodes of responsive behaviours over the next quarterly period; however no interventions were added to the plan of care in order to accomplish this objective.
-Data collected during a MDS review completed in August 2012 indicated there had been no change in the resident's behavioural status over the previous three months and the resident continued to demonstrate four identified responsive behaviours on a daily or almost daily basis. An assessment protocol note recorded in the clinical record in August 2012 again indicated that the plan was to review the care plan with the goal to decrease episodes of responsive behaviours over the next quarterly period; however no interventions were added to the plan of care to accomplish this objective.
- Data collected during a MDS review completed in November 2012 indicated that the resident's behaviour status had deteriorated and the resident continued to demonstrate responsive behaviours on a daily or almost daily basis. Data collected during a MDS review completed in February 2013 indicated there had been no change in the resident's behavioural status and the resident continued to demonstrate the identified responsive behaviours.
- Behavioural episodes documented by Personal Support Workers of the above noted 12 month period of time confirmed that the resident continued to demonstrate these behaviours on a daily or almost daily basis.
-Staff confirmed that the data collected for this resident over this 12 month period of time would indicate that the care being provided to the resident was not effective in reducing the episodes of responsive behaviours and also confirmed that the resident was not reassess and the care plan was not revised when the data indicated that