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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

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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
May 25, 2015;	2015_332575_0004 (A2)	S-000685-15	Resident Quality Inspection

Licensee/Titulaire de permis

WIKWEMIKONG NURSING HOME LIMITED
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

WIKWEMIKONG NURSING HOME
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

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GAIL PEPLINSKIE (154) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Review completed and findings amended in WN #1, #2 and #5 as requested by LTC Home.

Issued on this 19 day of June 2015 (A2)

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

Original report signed by the inspector.

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interactions, reviewed relevant health care records and reviewed numerous

licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
15 WN(s)
6 VPC(s)
6 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to resident #005.

Inspector #594 reviewed the resident's health care record which stated that resident #005 required total support for transferring and toileting. The inspector reviewed the care plan for the resident which stated that the resident required a two person assist for toileting and a one person extensive assistance for transferring.

The inspector interviewed S #100 who stated that the resident required two person assist for both transferring and toileting. The inspector interviewed S #101 who stated that the resident required one person assist. Upon review of the care plan, S #101 stated that the care plan does not give any direction for the number of staff required to assist the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to resident #006.

Inspector #594 reviewed the resident's health care record which stated that no bed

rails are used by the resident. The inspector observed the resident throughout the inspection with one quarter bed rail in use. During an interview with the inspector, resident #006 stated that one quarter bed rail is always in use.

A review of the resident's care plan by the inspector failed to identify bed rail use. Inspector #594 interviewed S #100 who stated that the resident required two quarter bed rails and would be identified in the kardex, which is accessible by direct care staff. The inspector interviewed S #101 who stated that the use of bed rails are to be documented in the resident's care plan and stated that resident #006 required one quarter bed rail. Upon review of the care plan, S #101 stated that the care plan failed to identify the use of any bed rails.

In addition, the Bed Rail Risk Assessment completed for resident #006 recommended one full length bed rail. Inspector #594 reviewed the home's policy titled 'Resident Safety 3.4 Bed Rails' dated July 07, 2012 and noted the policy indicated the use of bed rails should be documented clearly. [s. 6. (1) (c)]

3. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to resident #009.

Inspector #594 reviewed the resident health care record which stated no bed rails are used by the resident. The inspector observed the resident throughout the inspection with two quarter bed rails in use.

A review of the care plan by the inspector failed to identify the use of any bed rails. Inspector #594 interviewed S #100 who stated that two quarter bed rails were in use for mobility and it would be identified in the kardex, which is accessible by direct care staff. The inspector interviewed S #101 who stated that the use of bed rails are to be documented in the care plan and stated that resident #009's bed rails are just up, and not for any purpose. Upon review of the care plan, S #101 stated that the care plan failed to identify the use of any bed rails.

In addition, the Bed Rail Risk Assessment completed for resident #009 stated no bed rails are recommended. Inspector #594 reviewed the home's policy titled 'Resident Safety 3.4 Bed Rails' dated July 07, 2012 and noted the policy indicated the use of bed rails should be documented clearly. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #010.

Inspector #594 reviewed resident #010's health care record which identified the resident as incontinent of bladder. The plan of care was reviewed by the inspector which stated that the resident was continent of bladder.

Inspector #594 interviewed three staff (S #102, S #103, and S #104) who all stated that the resident was incontinent of bladder. Upon review of the resident's care plan, S #104 verified the care plan stated the resident was continent. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #010 as specified in the plan.

On three separate occasions, Inspector #594 observed resident #010 without the chair alarm attached when in their wheelchair.

Inspector #594 reviewed resident #010's care plan which identified that a chair alarm was to be attached when the resident was in their wheelchair and to apply a seat belt

Inspector #594 interviewed S #117 who stated that they were familiar with the resident's care but did not assist the resident with care that morning. When asked by the inspector if the resident required a chair alarm, S #117 stated it would be in the care plan and questioned the inspector if a chair alarm was on the resident's care plan. [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #010 as specified in the plan.

In four separate CIs submitted to the MOHLTC over a period of five months resident #010 was abusive to resident's #024, #026, and #014. Resident #010's the plan of care identified interventions to prevent abusive behaviours, however, in all four of the incidents the interventions were not provided as directed in the plan of care.

During an interview, S #120 confirmed to Inspector #575 that the care plan used by staff is in the home's electronic documentation system – PCC. Registered S #107 confirmed to Inspector #580 that PSWs can look at a printed copy of the care plan but mostly they look at PCC's POC kardex for care directions. Three staff (S #105, S #118, S #114) confirmed to Inspector #580 that they get care directions from the care plan/kardex on POC, however, S #118, S #105, S #106 confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for prevention of

physical aggression in regard to resident #010.

Inspector #580 reviewed resident #010's health care record which identified that the resident had a history of behaviours and that over a period of approximately three months there had been eight behaviour incidents in addition to the four submitted CI reports.

Inspector #580 reviewed the care plan of resident #010 which indicated interventions related to behaviours that included:

- initiating behavior mapping (DOS) after an incident to identify why the resident becomes angry or agitated (note time of day, who was present, and what preceded the incident, once complete review and analyze the data for trends). Registered staff S #101 confirmed that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #010;

- moving other residents away, moving other residents out of the area to ensure their safety, ensuring that personal space for the resident is maintained, to give them space and not to crowd them. In one CI, both residents were in the hallway. In another CI, both residents were sitting beside each other when resident #010 was in an altercation with resident #026;

- remove from public area when behaviour is disruptive and/or unacceptable. One CI indicated that resident #010 was verbally abusive to resident #014 in a public area when the incident occurred;

- removing any stimuli that may be adding to the stress. Resident #010's progress notes about one CI indicated that the resident was attending an activity with other residents. The care plan intervention of removing any stimuli that may be adding to the resident's stress was not implemented.

After interviews with staff, review of the resident's care plan and progress notes, Inspector #580 identified that care plan interventions to prevent further abuse were not implemented.

As a result, the licensee failed to ensure that the care set out in the plan of care was provided to resident #010 as specified in the plan. [s. 6. (7)]

7. The licensee has failed to ensure that the care set out in the plan of care was

provided to resident #022 as specified in the plan.

In four separate CIs submitted to the MOHLTC over a period of three months in which resident #022 was abusive to resident's #005, #013, #016, and #017. Resident #022's plan of care identified interventions to prevent abusive behaviours, however, in all the incidents the interventions were not provided as directed in the plan of care. [s. 6. (7)]

8. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #026 as specified in the plan.

In four separate CIs were submitted to the MOHLTC over a period of six months resident #026 was abusive to four residents (#005, #010, #021, and #022). In all the incidents, the interventions were not provided as directed in resident #026's plan of care.

Inspector #580 reviewed the care plan for resident #026 which indicated interventions related to behaviours that included:

a) If the resident begins to act aggressively toward other residents, remove them from the situation and redirect them to other activities;

b) Identify and remove any stimuli that may be adding to stress, move other residents away.

The care plan for resident #026 also indicated to ensure DOS charting was active. This intervention was not implemented.

As a result, the licensee failed to ensure that the care set out in the plan of care was provided to resident #026 as specified in the plan. [s. 6. (7)]

9. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

Two separate CIs submitted to the MOHLTC over a period of three months identified that resident #005 was abusive to two residents (#026 and #022). In both incidents, the interventions were not provided as specified in the plan of care.

Inspector #580 reviewed the care plan interventions of resident #005 which indicated that DOS charting was to be active and charted on every hour, that a congestion of hallways was to be avoided, and that the resident was to be reminded to ask staff to move other residents to ensure pathway clear. Another intervention related to behaviours indicated to be careful of not invading the resident's personal space. These interventions were not implemented related to two CIs, nor in the three other incidents of aggression.

Three staff (S #105, S #118, S #114) confirmed to the inspector that they did not know what behaviour interventions the care plan or kardex specified for resident #005.

Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with behaviour assessment tools including antecedent and consequences. Registered S #106 confirmed to Inspector #580 that DOS charting is to be completed in hard copy for 72 hours past the incident. Registered S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The BSO policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO who are on site at the home monthly. The Administrator confirmed to Inspector #580 that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. S #121 confirmed to the inspector that BSO completes assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart, but S #121 was not able to find any BSO referral for resident #005.

After interviews with staff, review of the resident's care plan and progress notes Inspector #580 identified that care plan interventions to prevent further abuse were not implemented.

As a result, the licensee failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan. [s. 6. (7)]

10. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #014 as specified in the plan.

Two separate CIs submitted to the MOHLTC over a period of two weeks, identified that resident #014 was abusive to resident #010. In both incidents, the interventions were not provided as specified in the plan of care.

Inspector #580 reviewed the care plan of resident #014 which indicated that for the goals to a) reduce incidents of verbal/physical aggressions to ensure the safety for residents and b) ensure the resident will not strike others, the interventions included:

-to move the resident to a quiet area; to remove the resident from public area when in confrontation with others. In both CIs, the resident was in the hallway with other residents, and the interventions were not implemented;

-to initiate behavior charting (DOS) to identify why the resident became so angry or agitated and include the time of day, who was present and what preceded the incident. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #014. This intervention was not implemented.

During interviews, four staff (S #118, S #114, S #105, S #106) confirmed to the inspector that they do not know what the care plan or kardex indicated for the prevention of verbal/physical aggression in regard to resident #014.

Throughout the inspection period, inspector #580 observed resident #014 seated in the crowded hallways.

After interviews with staff, review of the resident's care plan and progress notes Inspector #580 identified that even though, resident #014 had a history of behaviours, care plan interventions to prevent further abuse by resident #014 were not implemented.

As a result, the licensee failed to ensure that the care set out in the plan of care was provided to resident #014 as specified in the plan. [s. 6. (7)]

11. The licensee has failed to ensure that resident #004 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Inspector #575 reviewed resident #004's plan of care. The inspector noted that the resident used a medical device for incontinence. The health care record indicated that the resident was admitted to hospital and returned to the home several days later with the device. The resident did not require this device prior to the admission to hospital.

The inspector reviewed the resident's quarterly RAI-MDS assessments and noted the following: the assessment prior to hospital identified that the resident was incontinent and used pads/briefs, that interventions are in place, and that the resident was at greater risk for skin breakdown but had been getting optimal skin care and had not had any breakdown; then, the following two quarterly assessments identified that the resident was incontinent, used a medical device, pads/briefs, and that the resident utilized a medical device daily to prevent skin breakdown or ulcers.

The inspector was unable to determine the resident's requirement for the use of the medical device. The inspector interviewed S #107 who stated that the resident required this device due to the resident experiencing skin breakdown. The staff member confirmed to the inspector that the resident did not receive a continence assessment since returning from hospital with the medical device. The staff member further indicated that the home does not use an assessment tool and that assessments are completed via a progress note after a diary is completed.

The inspector interviewed the S #121 who stated that they are unsure why the resident had the device and confirmed that the device was not re-assessed since the resident returned from hospital. The staff member stated that the resident was overlooked and that it is not the home's practice to continue with the medical device without any reason. The staff member then made a referral for the physician to re-assess the use of the device.

Although the care plan reflected the use of the medical device, the resident was not re-assessed. [s. 6. (10) (b)]

12. The licensee has failed to ensure that resident #010 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Inspector #594 reviewed resident #010's health care record which identified the resident with impaired vision and required the use of glasses. The care plan was reviewed by the inspector which stated staff were to ensure the resident's eyeglasses

were clean, appropriate and being worn by the resident. During the course of the inspection, the inspector observed the resident without any eye glasses being used.

During an interview with the inspector, S #103 stated that the resident used to wear glasses when they were first admitted to the home, however it has been over two years since the resident has worn glasses. Inspector #594 interviewed S #104 who stated that the resident's glasses were broken and never replaced and stated that the intervention for ensuring the resident's glasses were in use should be removed from the care plan. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002, 004 will be served on the licensee. Refer to the "Order(s) of the inspector".

(A2)The following order(s) have been amended:CO# 004

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 ensuring that resident #004 and #010's plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used the resident and their bed system had been evaluated in accordance with evidence-based practices.

Inspector #594 observed resident #006 resting in bed with one quarter bed rail in use. During an interview with the inspector the resident stated the bed rail is always like that and staff have never changed the bed rails.

Inspector #594 observed resident #009 resting in bed with two quarter bed rails in use. The Bed Rail Risk Assessment completed for Resident #009 stated no bedrails are recommended.

Inspector #594 observed resident #010's bed system with two full bed rails engaged, however the resident was not observed in bed. No bed rail assessment was located in the plan of care by the inspector. The inspector reviewed the MDS assessment record which indicated the resident used full bed rails on all open sides of the bed daily. During an interview, S #103 stated that the resident requires two bed rails in use when in bed.

The inspector reviewed the home's 'Resident Safety Bed Entrapment Prevention Program' policy dated July 2012 that stated the home is to establish an interdisciplinary group responsible for measuring existing bed systems and taking corrective actions when indicated.

During an interview, S #121 stated that the maintenance staff is responsible for

assessing bed systems. During an interview S #111 stated to the inspector that the

residents' bed system are not evaluated. [s. 15. (1) (a)]

2. The licensee has failed to ensure where bed rails are used steps are taken to prevent resident entrapment.

Bed rails were observed in use by Inspector #594 for resident #006, #009, and #010.

The inspector reviewed the home's 'Resident Safety Bed Entrapment Prevention Program' policy dated July 2012 which stated staff are to assess the beds within the home to ensure that entrapment zones and risk are identified. The same policy identified seven zones of entrapment including dimensional limits. During an interview, S #121 stated that the maintenance staff are responsible for assessing zones of entrapment.

During an interview with the inspector, S #110 stated that they ensure that the residents' mattress fits the bed and that it would not be possible for residents' to become entrapped. Additionally, another staff stated that they do not assess for potential zones of entrapment. [s. 15. (1) (b)]

3. The licensee has failed to ensure that where bed rails are used other safety issues related to the use of bed rails were addressed, including height and latch reliability.

Bed rails were observed in use by Inspector #594 for resident #006, #009, and #010.

The inspector reviewed the home's 'Resident Safety Bed Entrapment Prevention Program' policy dated July 2012 which failed to identify how the home addresses other safety issues where bed rails are used such as height and latch reliability. The DOC stated to the inspector that the maintenance staff are responsible for assessing bed systems including other safety issues.

During an interview with the inspector, S #110 stated that bed rails only go to a certain height and they check latch reliability by engaging the bed rail. Another staff member stated that they do not assess height and latch reliability. [s. 15. (1) (c)]

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

A previous compliance order (CO) related to the Long-Term Care Home Act, s. 19 (1) was issued during inspection #2014_331595_0004 with a compliance date of November 1, 2014.

1. The licensee has failed to ensure that residents were protected from abuse by resident #010 in four separate critical incidents (CI) submitted to the Ministry of Health and Long Term Care (MOHLTC) over a period of five months in which resident #010 was abusive to resident #024, resident #026, and resident #014.

i). A CI related to resident abuse was reviewed by Inspector #580. According to the CI, a staff member reported that resident #010 was in an altercation with resident #024.

a. A staff member (S #120) confirmed to Inspector #575 that the care plan used by staff is in the home's electronic documentation system – Point Click Care (PCC). Staff member S #107 confirmed to Inspector #580 that PSWs can look at a printed copy of the care plan but mostly they look at PCC's Point Of Care (POC) Kardex for care directions. Inspector #580 reviewed resident #010's care plan and found no corresponding focus related to physical aggression on the care plan with print date of 02/24/15 and revision date of 10/23/14. The focus read "problematic manner in which resididents becomes abngry AEB verbal aggression toward staff or roommate". Three staff members (S #105, S #118, S #114) confirmed to Inspector #580 that they get care directions from the care plan/kardex on POC however, S #118, S #105, S #106 confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for prevention of physical aggression in regard to resident #010.

Inspector #580 reviewed resident #010's health care record which identified that the resident had a history of behaviours. The inspector reviewed the progress notes of resident #010 which indicated that for approximately three months there had been eight behavioural incidents in addition to the four submitted CI reports.

b. Inspector #580 reviewed the home's Abuse and Neglect Prevention Program, Appendix A – I, dated November 2014 which included a statement confirming zero tolerance of abuse and the requirement of staff to implement interventions to prevent further abuse. The inspector also reviewed the referral made to Behaviour Support Ontario (BSO) and the progress notes that identified the following:

- BSO met with resident #010 and their family member approximately six weeks after the incident;
- the MDS assessment indicated that interventions for verbal abusiveness to other residents are in place, effective and new interventions are not required;
- BSO met with resident #010 again on three occasions with approximately one month and left a few ideas of activities to complete with the resident;
- resident #010 was verbally aggressive with another resident on three occasions; and
- resident #010 was yelling at other residents in the hallway on two occasions.

c. Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes. Resident #010's physician was not notified after the CI. The policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO who are on site at the home monthly. A referral was made to BSO for resident #010 after the incident. The Administrator confirmed to Inspector #580 that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. S #121 confirmed to the inspector that they were not able to find the BSO written report for the resident.

d. Inspector #580 reviewed the home's CI policy dated August 2013, which indicated and the Administrator confirmed, that when abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified after the CI.

After interviews with staff, review of the resident's care plan and progress notes,

review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, Inspector #580 identified that the physician was not notified after the CI to determine if there were further resident actions required and to rule out medical and physiological causes and that the police were not notified.

As a result, the licensee failed to ensure that resident #024 was protected from abuse by resident #010.

ii). A CI related to resident abuse was reviewed by Inspector #580. According to the CI, resident #010 was in an altercation with resident #026.

a. Inspector #580 reviewed the care plan of resident #010 which indicated that the interventions related to behaviours included:

- removing the resident from public area when behaviour is disruptive and/or unacceptable. This intervention was not implemented;

- removing any stimuli that may be adding to this resident's stress. Resident #010's progress notes about the incident indicated that the resident was attending an activity with other residents. The care plan intervention of removing any stimuli that may be adding to the stress was not implemented;

- moving other residents away, moving other residents out of the area to ensure their safety, ensuring that personal space for the resident is maintained, to give them space and not to crowd them. In the CI report, both residents were sitting beside each other when resident #010 physically abused resident #026. The care plan intervention of ensuring that personal space for the resident was maintained, to give them space and not to crowd them was not implemented;

- initiating behavior mapping -Behaviour Daily Observation Sheet (DOS) after an incident to identify why the resident becomes angry or agitated (note time of day, who was present, and what preceded the incident, once complete review and analyze the data for trends). Registered staff S #101 confirmed that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #010.

b. Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions

required and to rule out medical and physiological causes. Resident #010's physician was not notified after the CI.

c. Inspector #580 reviewed the home's CI policy dated August 2013 which indicated and the Administrator confirmed, that when abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified after the CI.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, Inspector #580 identified that interventions to prevent further abuse were not implemented, that the physician was not notified after the CI to determine if there are further resident actions required and to rule out medical and physiological causes and that the police were not notified.

As a result, the licensee failed to ensure that resident #026 was protected from abuse by resident #010.

iii). A CI related to resident abuse was reviewed by Inspector #580. According to the CI, a staff member reported that resident #014 was in an altercation with resident #010. Subsequent to the incident, a BSO referral was made for resident #014 and BSO visited the resident approximately three weeks later. Resident #010 was being followed by BSO.

a. Inspector #580 reviewed the care plan of resident #010 which indicated that interventions related to behaviours included:

- remove from public area when behaviour is disruptive and/or unacceptable. Resident #010's care plan intervention of removing the resident from a public area when behaviour is disruptive/unacceptable was not implemented;

- removing any stimuli that may be adding to the stress. Inspector #580 reviewed the care plan of resident #014 which indicated that the resident had specific behaviours. In the CI the residents were overhead verbally interacting, resident #010's care plan interventions were not implemented as a resident assessed for specific behaviours caused the stimuli that added to resident #010's stress;

- initiate behavior mapping (DOS) after an incident to identify why the resident becomes angry or agitated (note time of day, who was present, and what preceded the incident, once complete review and analyze the data for trends). Registered staff

S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #010.

b. Inspector #580 reviewed the home's CI policy dated August 2013 which indicated and the Administrator confirmed that when abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified after the CI.

Inspector #580 reviewed resident #010's health care record which identified that the resident had an extensive history of behaviours. After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, Inspector #580 identified that interventions to prevent further abuse were not implemented and that the police were not notified.

As a result, the licensee failed to ensure that resident #014 was protected from abuse by resident #010.

iv). A CI related to resident abuse was reviewed by Inspector #580. A BSO referral was made for resident #014 and BSO visited the resident approximately nine days after the incident.

a. Inspector #580 reviewed the care plan of resident #010 which indicated interventions related to behaviours included:

- removing from public area when behaviour is disruptive and/or unacceptable.

- removing any stimuli that may be adding to the stress. Inspector #580 reviewed the care plan of resident #014 which indicated that the resident had specific behaviours.

- moving other residents away, move other residents out of the area to ensure their safety. Ensure to maintain personal space for the resident. Do not crowd them, give them space. In the CI, both residents were in the hallway;

- initiating behavior mapping (DOS) after an incident to identify why the resident

becomes angry or agitated (note time of day, who was present, and what preceded the incident, once complete review and analyze the data for trends). Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #010.

b. Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes. Resident #010's physician was not notified after the CI.

c. Inspector #580 reviewed the home's CI policy dated August 2013 which indicated and the Administrator confirmed that when abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified after the CI.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, Inspector #580 identified that interventions to prevent further abuse were not implemented, that the physician was not notified after the CI to determine if there are further resident actions required and to rule out medical and physiological causes, and that the police were not notified.

As a result, the licensee failed to ensure that resident #014 was protected from abuse by resident #010. [s. 19. (1)]

2. The licensee has failed to ensure that residents were protected from abuse by resident #022.

For a period of approximately two months, four CIs were reported to the Director related to abuse by resident #022 toward four other residents in the home (#005, #013, #016, and #017). Inspector #580 reviewed resident #022's health care records including the care plan, PCC progress notes, MDS assessments, and POC flow sheets.

The inspector reviewed the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy which identified that when a resident exhibits responsive behaviours, staff are to:

- assess the resident with behaviour assessment tools including antecedent and

consequences;
- notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes; and
- make referrals to BSO (the Administrator confirmed to that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work). The DOC was not able to find the BSO report for resident #022.

The home confirmed there is zero tolerance of abuse and the requirement to implement interventions to prevent further abuse. The Administrator confirmed that when abuse occurs, the staff are trained to call the police if there was intent to harm.

The inspector interviewed staff who reported that:

- DOS charting is completed in hard copy for 72 hours past the incident but that DOS charting did not usually get done and that DOS charting was not completed on resident #022;
-resident #022 had a history of behaviours; and
-staff did not know what resident #022's care plan or kardex indicated regarding interventions for behaviours.

The Administrator confirmed that resident #022 was aggressive, that it helped to keep the resident busy with activity, that when the staff assessed the incidents of aggression they realized they needed activities in the evening, but confirmed there is no record of this plan.

During an interview, resident #022 confirmed to the inspector that they felt safe in the home and protected, but that they protected themselves with their fists and raised their fists to indicate to the inspector that they would punch.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, the inspector identified that staff were not aware of the interventions in place to prevent physical abuse, that the physician was not notified after three CIs to determine if there were further resident actions required and to rule out medical and physiological causes and that the police were not notified.

As a result, the licensee failed to ensure that resident's #005, #013, #016, and #017

were protected from abuse by resident #022. [s. 19. (1)]

3. The licensee has failed to ensure that residents were protected from abuse by resident #026 in four separate CIs submitted to the MOHLTC over a period of six months during which resident #026 was abusive to four residents (#005, #010, #021, and #022).

Inspector #580 reviewed resident #026's health care record which identified that the resident had a history of behaviours. In addition, the inspector reviewed the progress notes of resident #026 which indicated that for a period of approximately six months, there were three further aggressive incidents.

Inspector #580 reviewed the home's Abuse and Neglect Prevention Program, Appendix A – I, dated November 2014 which included a statement confirming zero tolerance of abuse and the requirement to implement interventions to prevent further abuse. The inspector reviewed resident #026's progress notes which indicated that the resident was discharged from the BSO program following five aggressive incidents in four months, that two more aggressive incidents occurred in the following two months, and that BSO indicated that a re-referral could be done at any time and that the home just needed to call the clinician. The inspector reviewed the care plan and progress notes and noted no new referral was made to BSO.

Inspector #580 reviewed the home's CI policy dated August 2013, which indicated that the home would submit required reports to the Director and that any modifications and/or updates to the CIs can be made within 10 days of initiating the form. The MOHLTC requested the home amend two CIs submitted to provide further information. The inspector reviewed the MOHLTC's CI Reports web site which confirmed that the home had not updated the information requested by the Director for either CI.

The CI policy also indicated, and the Administrator confirmed, that when abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified for any of the four submitted CIs.

Inspector #580 reviewed the care plan of resident #026 which indicated interventions related to behaviours that included:

a) If the resident begins to act aggressively toward other residents, remove them from the situation and redirect them to other activities;

b) Identify and remove any stimuli that may be adding to stress, move other residents away.

The care plan of resident #026 also indicated to ensure DOS charting was active. This intervention was not implemented.

Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with behaviour assessment tools including the antecedent and consequences. Registered staff S #106 and confirmed to Inspector #580 that DOS charting is to be completed in hard copy for 72 hours past the incident. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done.

The policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO who are on site at the home monthly. The Administrator confirmed to the inspector that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. S #121 confirmed to the inspector that BSO completes assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart, but S #121 was not able to find any BSO referral for resident #026.

The home's policy further indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes. The physician was not notified for two CIs.

During interviews, three staff (S #105, S #118, S #114) confirmed to the inspector that they did not know what behaviour interventions the care plan or kardex indicated for resident #026. Additionally, S #114 told the inspector of an intervention that worked to reduce the resident's behaviours, however, this intervention was not included in the care plan.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and

Behaviour Support Policy, Inspector #580 identified that staff were not aware of the interventions in place to prevent physical abuse, that the physician was not notified after two CIs to determine if there were further resident actions required and to rule out medical and physiological causes and that the police were not notified.

As a result, the licensee failed to ensure that resident's #005, #010, #021, and #022 were protected from abuse by resident #026. [s. 19. (1)]

4. The licensee has failed to ensure that residents were protected from abuse by resident #005. Two separate CIs were submitted to the MOHLTC over a period of three months during which resident #005 was abusive to two residents (#026 and #022).

Inspector #580 reviewed resident #005's health care record which identified that the resident had a history of behaviours. In addition, the inspector reviewed the progress notes of resident #005 which indicated that over a period of approximately three months, there were three further aggressive incidents.

Inspector #580 reviewed the home's Abuse and Neglect Prevention Program, Appendix A – I, dated November 2014 which included a statement confirming zero tolerance of abuse and the requirement to implement interventions to prevent further abuse. The inspector reviewed resident #005's progress notes which indicated: that the resident was referred to the BSO program and discharged from the program approximately two and a half months later, that three more aggressive incidents occurred in the following two months, and that the BSO clinician indicated in the progress notes that a re-referral could be requested. The inspector reviewed the care plan and progress notes and noted no new referral was made to BSO. The inspector reviewed the completed BSO form; the physician consult indicated that medication was prescribed for the resident's behaviour but apologized that they could not be more helpful and hoped that BSO might help staff deal with the resident's behaviours.

Inspector #580 reviewed the care plan interventions of resident #005 which indicated that DOS charting was to be active and charted on every hour, that a congestion of hallways was to be avoided, and that the resident was to be reminded to ask staff to move other residents to ensure pathway clear. Another intervention related to behaviours indicated to be careful of not invading the resident's personal space. These interventions were not implemented related to two CIs, nor in the three other incidents of aggression.

During interviews, three staff (S #105, S #118, S #114) confirmed to the inspector that they did not know what responsive behaviour interventions the care plan or kardex indicated for resident #005.

Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with behaviour assessment tools including the antecedent and consequences. Registered staff S #106 confirmed to Inspector #580 that DOS charting is to be completed in hard copy for 72 hours past the incident. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. S #121 confirmed to the inspector that DOS charting was not completed on resident #005.

The policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO who are on site at the home monthly. The Administrator confirmed to the inspector that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. S #121 confirmed to the inspector that BSO completes assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart, but S #121 was not able to find a new BSO referral for resident #005 after their discharge from the BSO program.

Additionally, the policy indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes. The physician was not notified for the CI.

Inspector #580 reviewed the home's CI policy dated August 2013, which indicated, and the Administrator confirmed, that when abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified for two CIs.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, Inspector #580 identified that interventions were not implemented to prevent physical abuse, that staff were not aware of the interventions in place, that the physician was not notified after a CI to determine if there were further resident actions required and to rule out medical and physiological causes and that

the police were not notified.

As a result, the licensee failed to ensure that resident #026 and #022, were protected from abuse by resident #005. [s. 19. (1)]

5. The licensee has failed to ensure that resident #010 was protected from abuse by resident #014 in two separate CIs submitted to the MOHLTC over a period of two weeks.

One CI identified that resident #010 was in an altercation with resident #014 and another CI identified that resident #010 had sustained an injury from an altercation with resident #014.

Inspector #580 reviewed resident #014's health care record which identified that the resident had a history of behaviours. In addition, the inspector reviewed the progress notes of resident #014 which indicated that over a period of approximately two months, there were four further aggressive incidents.

Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with behaviour assessment tools including the antecedent and consequences. Registered staff S #106 confirmed to the inspector that DOS charting is to be completed in hard copy for 72 hours past the incident. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. S #121 confirmed to the inspector that DOS charting was not completed on resident #014.

The policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO. A referral was made to BSO on December 29, 2014 for resident #014. The Administrator confirmed to the inspector that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. S #121 confirmed to the inspector that they were not able to find the BSO written report for resident #014.

Inspector #580 reviewed the care plan for resident #014 which indicated interventions related to behaviours that included:

-to move the resident to a quiet area and to remove the resident from public area

when in confrontation with others.

-to initiate behavior charting (DOS) to identify why the resident became so angry or agitated and include the time of day, who was present and what preceded the incident. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #014. This intervention was not implemented.

During interviews, four staff (S #118, S #114, S #105, S #106) confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for the prevention of aggression in regard to resident #014.

Inspector #580 reviewed the home's CI policy dated August 2013 which indicated and the Administrator confirmed that when resident to resident abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified after either CI.

As a result, the licensee failed to ensure that resident #010 was protected from abuse by resident #014. [s. 19. (1)]

Additional Required Actions:

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

A2- The following order(s) have been amended: CO #001

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred immediately reported the suspicion and the information upon which it is based to the Director.

Inspector #580 reviewed the home's CI policy dated August 2013 which indicated that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately be reported to the MOHLTC.

During an interview, the Administrator confirmed to Inspector #580 that when resident to resident abuse occurs, the home is to immediately submit a CI report to the MOHTLC. The Administrator also confirmed that the following four CIs were not submitted immediately to the Director, even though they were notified right away:

CI #1 was submitted eight days after the incident;

CI #2 was submitted five days after the incident;

CI #3 was submitted two days after the incident; and

CI #4 was submitted two days after the incident. [s. 24. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Inspector #575 reviewed meeting minutes for the Residents' Council for three months. The inspector noted the meeting minutes identified concerns and recommendations by the Council, including but not limited to, issues regarding smoking in the front entrance, meal service, food quality, missing clothing items, staffing, and bathing.

During an interview, S #115 stated that concerns and recommendations identified by the Council are brought forward by the Residents' Council assistant to the relevant personnel via email. The staff member stated that the relevant personnel follow up face to face with the resident who had the concern and that no responses are provided in writing.

During an interview, the Administrator confirmed that the home does not respond in writing to the concerns or recommendations identified by the Residents' Council. [s. 57. (2)]

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response is provided within 10 days of receiving Family Council advice related to concerns or recommendations.

Inspector #575 reviewed meeting minutes for the Family Council for one month. The inspector noted the meeting minutes identified concerns and recommendations by the Council, including but not limited to, issues regarding smoking in the front entrance, meals and snacks, activities, and missing items.

During an interview, the Administrator stated that the concerns and recommendations identified in the meeting minutes were brought forward to the required personnel and addressed, however the Administrator stated that the home does not respond in writing to the concerns or recommendations identified by the Family Council.

The Family Council representative also stated to the inspector that they have not received any response from the home regarding the November meeting. [s. 60. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,

(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(c) that the local medical officer of health is invited to the meetings; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is an interdisciplinary team approach in the co-ordination and implementation of the infection prevention and control program (IPAC).

During an interview with Inspector #594, S #121 stated that S #101 was the designated staff member coordinating the IPAC program. The inspector interviewed S #101 who stated that they were not the designated lead. Inspector #594 interviewed the Administrator who stated S #104 and S #121 were co-leads of the IPAC program. During an interview, S #104 stated that they, along with two housekeeping staff, four PSWs, and the DOC are currently attending the IPAC team meetings.

The inspector reviewed the home's policy titled 'Infection Prevention and Control Committee' dated August 2013, which stated the IPAC committee members included the IPAC Practitioner, the Medical Advisory Physician, Occupational Health, Public health and Environmental Services representatives, the DOC, Recreation and Leisure Coordinator, Registered Dietitian, Nutritional Manager and the Administrator. [s. 229. (2) (a)]

2. The licensee has failed to ensure that the IPAC interdisciplinary team met quarterly.

During an interview with Inspector #594, the DOC stated that S #101 was the designated staff member coordinating the IPAC program. The inspector interviewed S #101 who stated that they were not the designated lead.

Inspector #594 interviewed the Administrator who stated S #104 and S #121 were co-leads of the IPAC program. During an interview, S #104 stated they had only joined the committee the previous month, that the team meets monthly and their last meeting the home was declared in a respiratory outbreak.

Inspector #594 reviewed the home's IPAC manual binder and failed to identify IPAC meeting minutes. The inspector interviewed the Administrator who stated that any meeting minutes would be located at the back of the binder. [s. 229. (2) (b)]

3. The licensee has failed to invite the local Medical Officer of Health to IPAC team meetings.

During an interview, S #104 stated that the Medical Officer of Health nor any other representative from the Public Health Unit are invited to the IPAC meetings. [s. 229. (2) (c)]

4. The licensee has failed to ensure the IPAC program had been evaluated and updated at least annually in accordance with evidence-based practices.

Inspector #594 reviewed the home's 'Infection Prevention and Control Program' policy dated August 2013 which failed to identify program evaluation and updates. During an interview with the inspector, S #104 stated they were unsure if the IPAC program was evaluated. The inspector interviewed the Administrator who stated nursing policies, including the IPAC program, were created by S #120 in 2013. The Administrator stated that S #120 updated the policies and sends them to the home, however there were no records of any updates made. The Administrator further stated that they are not aware of any program evaluation or who would have attended if it had been completed. [s. 229. (2) (d)]

5. The licensee has failed to ensure that there is a designated staff member to co- ordinate the IPAC program with education and experience in IPAC practices.

During an interview with Inspector #594, S #121 stated that S #101 was the designated staff member coordinating the IPAC program. The inspector interviewed S #101 who stated that they were not the designated lead. Inspector #594 interviewed the Administrator who stated S #104 and S #121 were co-leads of the IPAC program.

During an interview, S #104 stated they have no experience in IPAC practices but they had recently completed some Public Health Ontario IPAC courses. The inspector interviewed S #121 who stated they have no education or experience in IPAC practices.

The inspector reviewed the home's policy titled 'Infection Prevention and Control Committee' dated August 2013 which stated that the IPAC Practitioner shall hold a current registration with the College of Nurses of Ontario, either as a Registered Nurse or Registered Practical Nurse with additional formal education and experience in the following:

a) Infectious diseases; epidemiology and outbreak management, microbiology
b) Cleaning and disinfection;
c) Data collection and trend analysis;
d) Reporting protocols;
e) Outbreak management;
f) Resident care practices; and
g) Occupational health. [s. 229. (3)]

6. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Inspector #575 observed S #101 administer medication to three residents. Handwashing was observed before administration to the first resident and after administration to the last resident, however, handwashing was not observed between each resident. [s. 229. (4)]

7. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Inspector #594 observed the dinner meal service. Two staff members (S #109 and S #108) were observed by the inspector clearing dinner plates and table items, completing resident meal intake records, and then serving dessert without completing hand hygiene prior to serving dessert.

On the same day the inspector observed a resident room with Personal Protective Equipment (PPE) located inside of the resident room however no signage was visible indicating any isolation precautions. S #121 verified that the resident room was on contact precautions and verified no signage was posted for contact precautions.

During another meal service, the inspector observed a staff member feeding a resident, then lead another resident to their table by the hand and return to the first resident and continue feeding without hand hygiene. Another staff member was observed by the inspector to be scratching their arm, and then proceeded to serve dessert with no hand hygiene completed.

The inspector reviewed the home's 'Hand Hygiene' policy dated August 2013 which stated that hands should be washed before preparing, handling, serving, or eating food and before feeding a resident.

The inspector reviewed the home's 'Infection Prevention and Control Program' policy dated August 2013 that stated the core functions of IPAC focus on strategies to protect residents, staff and others from exposure to infections which include but are not limited to communication of infection-related issues and relevant practices to staff. [s. 229. (4)]

8. The licensee has failed to ensure that the information gathered on every shift about the residents' infections were analyzed daily to detect the presence of infection and

reviewed at least monthly to detect trends for the purpose of reducing the incidence of infection and outbreaks.

Inspector #594 interviewed S #104 and S #106 who stated that registered staff monitor residents daily for signs of infection and complete the Line Listing form but were unsure if the information is analyzed. The inspector interviewed S #121 who stated that there was no analysis of information gathered about the resident's infections to detect trends. [s. 229. (6)]

9. The licensee has failed to ensure there is a hand-hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspector #594 observed the dinner meal service. Staff S #109 and S #108 were observed by the inspector clearing dinner plates and table items, completing resident meal intake records, and then serving dessert without completing hand hygiene prior to serving dessert. During another meal service, the inspector observed a staff member feeding a resident, then lead another resident to their table by the hand and return to the first resident and continue feeding without hand hygiene. Another staff was observed by the inspector to be scratching their arm, and then proceed to serve dessert with no hand hygiene completed.

The inspector interviewed the Administrator who stated there is no hand-hygiene program at the home. [s. 229. (9)]

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 ensuring that there is an interdisciplinary team approach in the co-ordination and implementation of the IPAC program, that the interdisciplinary team meets quarterly, that they invite the local Medical Officer of Health to the meetings, that the IPAC program is evaluated and updated at least annually in accordance with evidence-based practices, that the information gathered on every shift about residents' infections are analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infection and outbreaks, that there is a designated staff member to co-ordinate the IPAC program with education and experience in IPAC practices, that there is a hand-hygiene program in place, and that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee failed to make a final report to the Director within a period of time specified by the Director (21 Days) after providing a preliminary report within 10 days.

Inspector #580 reviewed the home's CI policy dated August 2013, which indicated that the home would submit required reports to the MOHLTC and that any modifications and/or updates to the CIs can be made within 10 days of initiating the form. One two separate occasions, the MOHLTC requested the home amend the CI submitted and to provide further information. The inspector reviewed the MOHLTC's CI Reports web site which confirmed that the home did not update the information in a final report to the Director for either CI. [s. 104. (3)]

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 ensuring that if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director (21 days), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that for resident #005 who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours, and actions were taken to respond to the needs of the resident including assessments, reassessments and interventions.

Two separate CIs were submitted to the MOHLTC over a period of three months during which resident #005 was abusive to two residents (#026 and #022). Inspector

#580 reviewed resident #005's health care record which identified that the resident had a history of behaviours. In addition, the inspector reviewed the progress notes of resident #005 which indicated that for a period of approximately three months, there were three further aggressive incidents that did not incur CI reporting.

Inspector #580 reviewed the home's Abuse and Neglect Prevention Program, Appendix A – I, dated November 2014 which included requirement to implement interventions to prevent further abuse. The inspector reviewed resident #005's progress notes which indicated that the resident was referred to the BSO program and discharged from the program approximately two and a half months later, that three more aggressive incidents occurred in the following two months, and that the BSO clinician indicated in the progress notes that a re-referral could be requested. The inspector reviewed the care plan and progress notes and noted no new referral was made to BSO.

Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with behaviour assessment tools including the antecedent and consequences. Registered staff S #106 the confirmed to the inspector that DOS charting is to be completed in hard copy for 72 hours past the incident. Registered staff S #101 confirmed to the inspector that DOS charting did not usually get done.

The policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO who are on site at the home monthly. The Administrator confirmed to the inspector that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. S #121 confirmed to the inspector that BSO completes assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart, but S #121 was not able to find a new BSO referral for resident #005 after their discharge from the BSO program.

Additionally, the policy also indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes. The physician was not notified after the CI.

Inspector #580 reviewed the care plan interventions of resident #005 which indicated

that DOS charting was to be active and charted on every hour, that a congestion of hallways was to be avoided, and that the resident was to be reminded to ask staff to move other residents to ensure pathway clear. Another intervention related to behaviours indicated to be careful of not invading the resident's personal space. These interventions were not implemented related to two CIs, nor in the three other incidents of aggression.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program and Behaviour Support Policy, Inspector #580 identified that strategies were not implemented to respond to the responsive behaviours listed in resident #005's care plan, and actions stated in the home's policies and listed in resident #005's care plan were not taken to respond to the needs of the resident #005 including assessments, reassessments and interventions. [s. 53. (4)]

2. The licensee has failed to ensure that for resident #010 who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours and actions were taken to respond to the needs of the resident including assessments, reassessments and interventions.

Four separate CIs were submitted to the MOHLTC over a period of five months during which resident #010 was abusive to three residents (#014, #024 and #026). Inspector #580 reviewed resident #010's health care record which identified that the resident had a history of behaviours. In addition, the inspector reviewed the progress notes of resident #010 which indicated that for a period of approximately three months, there were eight further aggressive incidents in addition to the four submitted CI reports.

During an interview, S #106 confirmed to the inspector that DOS charting is to be completed in hard copy for 72 hours past the incident. Another staff (S #101) confirmed to the inspector that DOS charting did not usually get done. The DOC confirmed to the inspector that DOS charting was not completed on resident #010, contrary to interventions listed in the home's Behavioural Support Program policy.

Resident #010's physician was not notified after one of the CIs, contrary to interventions indicated in the home's Behavioural Support Program policy.

A referral was made to BSO for resident #010. The Administrator confirmed to Inspector #580 that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the

situation had changed or the intervention had already been tried and did not work. Approximately five months after the referral, the DOC confirmed to the inspector that they were not able to find the BSO written report for the resident, contrary to interventions listed in the home's Behavioural Support Program policy.

Inspector #580 reviewed the care plan of resident #010 which indicated interventions related to behaviours that included:

- removing the resident from public area when behaviour is disruptive and/or unacceptable. This intervention was not implemented;

- removing any stimuli that may be adding to this resident's stress. Resident #010's progress notes about the incident indicated that the resident was attending an activity with other residents. The care plan intervention of removing any stimuli that may be adding to the stress was not implemented;

- moving other residents away, moving other residents out of the area to ensure their safety, ensuring that personal space for the resident is maintained, to give them space and not to crowd them. In the CI report, both residents were sitting beside each other when resident #010 physically abused resident #026. The care plan intervention of ensuring that personal space for the resident was maintained, to give them space and not to crowd them was not implemented;

- initiating behavior mapping (DOS) after an incident to identify why the resident becomes angry or agitated (note time of day, who was present, and what preceded the incident, once complete review and analyze the data for trends). Registered staff S #101 confirmed that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #010.

During an interview, S #120 confirmed to Inspector #575 that the care plan used by staff is in the home's electronic documentation system – PCC. S #107 confirmed to Inspector #580 that PSWs can look at a printed copy of the care plan but mostly they look at PCC POC's Kardex for care directions. Three staff (S #105, S #118, S #114) confirmed to Inspector #580 that they get care directions from the care plan/kardex on POC however S #118, S #105, and S #106 confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for prevention of physical aggression in regard to resident #010.

Throughout the inspection period, inspector #580 observed resident #010 seated in crowded hallways and lounge areas.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program and Behaviour Support Policy, Inspector #580 identified that strategies were not implemented to respond to the responsive behaviours listed in resident #010's care plan, and actions stated in the home's policies and listed in resident #010's care plan, were not taken, to respond to the needs of the resident #010 including assessments, reassessments and interventions. [s. 53. (4)]

3. The licensee has failed to ensure that for resident #014 who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours and actions were taken to respond to the needs of the resident including assessments, reassessments and interventions.

Two separate CIs were submitted to the MOHLTC over a period of two weeks during which resident #014 was abusive to resident #010. Inspector #580 reviewed resident #014's health care record which identified that the resident had a history of behaviours. In addition, the inspector reviewed the progress notes of resident #014 which indicated that for a period of approximately two months, there were four further aggressive incidents that did not incur CI reporting.

During an interview, S #106 confirmed to the inspector that DOS charting is to be completed in hard copy for 72 hours past the incident. Another staff (S #101) confirmed to the inspector that DOS charting did not usually get done. S #121 confirmed to the inspector that DOS charting was not completed on resident #014 as indicated by the home's Behavioural Support Program policy for behaviour interventions.

The Administrator confirmed to the inspector that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention has already been tried and did not work. S #121 confirmed to the inspector that BSO completes assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart,

but S #121 was not able to find the BSO written report for resident #014 as indicated by home's Behavioural Support Program policy for behaviour interventions.

Inspector #580 reviewed the care plan for resident #014 which indicated interventions related to behaviours that included:

-to move the resident to a quiet area and to remove the resident from public area when in confrontation with others. In both CIs, the resident was in the hallway with other residents

-to initiate behavior charting (DOS) to identify why the resident became so angry or agitated and include the time of day, who was present and what preceded the incident. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #014. This intervention was not implemented, nor in the four other incidents of aggression.

Four staff (S #105, S #118, S #114, S #106) confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for the prevention of aggression in regard to resident #014.

Throughout the inspection period, inspector #580 observed resident #014 seated in crowded hallways.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program and Behaviour Support Policy, Inspector #580 identified that strategies were not implemented to respond to the responsive and aggressive behaviours as identified in resident #014's care plan, and actions stated in the home's policies and listed in resident #014's care plan were not taken, to respond to the needs of the resident #014 including assessments, reassessments and interventions. [s. 53. (4)]

4. The licensee has failed to ensure that for resident #022 who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours and actions were taken to respond to the needs of the resident including assessments, reassessments and interventions.

Four separate CIs were submitted to the MOHLTC over a period of three months in which resident #022 was abusive to resident's #005, #013, #016, and #017. Resident

#022's health care record identified that the resident has a history of behaviours. Also, the inspector reviewed the progress notes of resident #022 which indicated that for a period of approximately three months, there were eight aggressive outbursts that did not incur CI reporting.

During an interview, S #106 confirmed to the inspector that DOS charting is to be completed in hard copy for 72 hours past the incident. Another staff S #101 confirmed to the inspector that DOS charting did not usually get done. S #121 confirmed to the inspector that DOS charting was not completed for resident #022 as indicated by the home's Behavioural Support Program policy for behaviour interventions.

The Administrator confirmed that resident #022 was aggressive, that it helped to keep the resident busy with activity, that when the staff assessed the incidents of aggression they realized they needed activities in the evening, but confirmed there is no record of this plan.

The Administrator confirmed to Inspector #580 that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. S #121 confirmed to the inspector that BSO sends written reports to the home's behaviour referrals and that these reports are placed in the resident's chart, but S #121 was not able to find the BSO report for resident #022 as indicated by home's Behavioural Support Program policy for behaviour interventions.

Resident #022's physician was not notified after one of the CIs as indicated in the home's Behavioural Support Program policy.

Inspector #580 reviewed the care plan of resident #022 which indicated interventions related to behaviours that included:

a) Move them to a quiet area as they are physically aggressive in noisy overcrowded situations and when they feel threatened by other residents. This intervention was not implemented. One CI indicated that resident #022 was sitting in the lounge;

b) Move them to a quiet area and try to divert their attention. This intervention was not implemented. One CI indicated that resident #022 was sitting in the lounge; and

c) Keep resident active in the morning and encourage rest periods after lunch. This intervention was not implemented.

Four staff (S #105, S #118, S #114, S #106) confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for the prevention of aggression in regard to resident #022. In four different CIs submitted to the MOHLTC over a period of three months during which resident #022 was abusive to four residents and the plan of care identified interventions to prevent abusive behaviours, however, in all the incidents the interventions were not provided as directed in the plan of care.

Throughout the inspection period, inspector #580 observed resident #022 seated near other residents. During an interview, resident #022 confirmed to the inspector that they felt safe in the home and protected, but that they protected themselves with their fists and raised their fists to indicate to the inspector that they would punch.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program and Behaviour Support Policy, Inspector #580 identified that strategies were not implemented to respond to the responsive behaviours as identified in resident #022's care plan, and actions stated in the home's policies and listed in resident #022's care plan were not taken to respond to the needs of the resident including assessments, reassessments and interventions. [s. 53. (4)]

5. The licensee has failed to ensure that for resident #026 who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours, and actions were taken to respond to the needs of the resident including assessment, reassessments and interventions.

Four separate CIs were submitted to the MOHLTC over a period of three months in which resident #026 was abusive to resident's #005, #010,#021, and #022. Resident #026's health care record identified that the resident had a history of behaviours. In addition, the inspector reviewed the progress notes of resident #026 which indicated that for a period of approximately six months, there were three other aggressive outbursts that did not incur CI reporting.

During an interview, S #106 confirmed to Inspector #580 that DOS charting is to be completed in hard copy for 72 hours past the incident. Another staff (S #101) confirmed to Inspector #580 that DOS charting did not usually get done. S #121 confirmed to the inspector that DOS charting was not completed on resident #026 as indicated in the home's Behavioural Support Program policy.

The inspector reviewed resident #026's progress notes which indicated the resident was discharged from the BSO program following five aggressive incidents in four months, that two more aggressive incidents occurred in the following two months, and that the BSO clinician indicated in the progress notes that a re-referral could be done at any time and that the home just needed to call the clinician. The inspector reviewed the care plan and progress notes and noted no new referral was made to BSO as indicated.

The Administrator confirmed to the inspector that BSO made recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. S #121 confirmed to the inspector that BSO completes assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart, but S #121 was not able to find a new BSO referral for resident #026 as indicated by home's Behavioural Support Program policy for behaviour interventions.

Resident #026's physician was not notified for two of the CIs as indicated in the home's Behavioural Support Program policy.

Inspector #580 reviewed the care plan of resident #026 which indicated interventions related to behaviours that included:

a) If the resident begins to act aggressively toward other residents, remove them from the situation and redirect them to other activities;

b) Identify and remove any stimuli that may be adding to stress, move other residents away.

The care plan of resident #026 also indicated to ensure DOS charting was active. This intervention was not implemented.

Three staff (S #105, S #118, S #114) confirmed to the inspector that they did not know what responsive behaviour interventions the care plan or kardex indicated for resident #026. Additionally, S #114 told the inspector of an intervention that worked to reduce the resident's behaviours, however, this intervention was not included in the care plan.

In the four separate CIs submitted to the MOHLTC over a period of six months during which resident #026 was abusive to four residents, interventions were not provided as directed in resident #026's plan of care.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program and Behaviour Support Policy, Inspector #580 identified that strategies were not implemented to respond to the responsive behaviours as identified in resident #026's care plan and actions stated in the home's policies and listed in resident #026's care plan were not taken to respond to the needs of the resident including assessments, reassessments and interventions. [s. 53. (4)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".
(A2) The following order(s) have been amended: CO #006

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy titled 'Weight Management Program' is complied with.

During an interview, the DOC stated that resident's weights are to be entered into PCC during the first week of each month. On February 19, 2015, Inspector #575 noted that 10/20 resident's did not have weights entered into PCC for the month of February 2015 and 2/20 resident's did not have a weight entered for August 2014, and 1/20 resident's did not have a weight entered for November 2014.

The Administrator provided the inspector with the home's policy titled 'Weight Management Program' that indicated all residents are to be weighed monthly and the weights will be completed during the first week of each month on the first bath day of that week. [s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's policy titled 'Behavioural Support Program' dated August 2013 is complied with.

Inspector #580 reviewed the home's policy titled 'Behavioural Support Program' dated August 2013. The policy indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with the assessment tools to track behaviour, including antecedent and consequences. The policy further indicated behaviour documentation should be completed for a seven day period.

The inspector interviewed the S #106 who stated that the DOS charting is completed in hard copy for 72 hours after an incident of responsive behaviours. During an interview S #101 stated that DOS charting did not usually get done.

The inspector reviewed the health care records for eight residents who displayed responsive behaviours (#005, #010, #013, #014, #015, #020, #022, #026). The DOC confirmed to the inspector that DOS charting was not completed for any of the eight residents. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 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 ensuring that the home's 'Weight Management Program' policy is complied with, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart,
i. that is used exclusively for drugs and drug-related supplies,
ii. that is secure and locked,
iii. that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
iv. that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

On February 18, 2015 Inspector #575 observed a medicated shampoo in a tub room

for resident #027 and observed four medicated cream/lotions in resident #004's bedside table.

The inspector reviewed resident #004's health care record and noted that one of the cream/lotions was discontinued for approximately five months, another cream/lotion was discontinued for approximately eight months and there was no current order to leave the medication at the resident's bedside.

The inspector and S #106 observed the resident's bedside table. Two medicated cream/lotions were observed in the table by S #106, were removed, and S #106 confirmed that the medications should not be stored in the bedside table.

The inspector reviewed resident #027's health care record and noted that the resident no longer resided in the home since January 20, 2015.

The inspector interviewed S #106 and S #116. They both stated that prescription creams/lotions and shampoo should be stored in the medication carts and not in resident rooms or the tub rooms.

The inspector reviewed the home's policy titled 'Medication Storage' that indicated medication should be stored in the cart or in the designated area of the medication room. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #575 observed the medication room on February 25, 2015. The inspector noted that the home's emergency drug supply was located in a locked toolbox located on the counter in the locked medication room. The emergency drug supply included the controlled substances lorazepam and morphine. This was confirmed by S #104.

The emergency drug box contained controlled substances and was not double locked in a stationary cupboard within the locked medication room. [s. 129. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Inspector #575 reviewed resident #001's health care record. The inspector noted that the resident's most recent RAI-MDS assessment indicated that the resident had an increase of pain compared to the previous assessment. The resident's pain increased from no pain to mild pain less than daily.

The progress notes indicated that the resident was given Tylenol for complaints of pain related to an incident that occurred the previous day. The inspector reviewed the residents Medication Administration Record (MAR) and noted that the administration of Tylenol on that day was not recorded, nor was the effectiveness of the medication.

The inspector interviewed S #121 regarding the documentation of pain management. The staff member stated that the expectation is that when a medication is given it is recorded on the MAR and the effectiveness of the medication is also documented in the MAR. They confirmed that the documentation was missing for that administration.

The inspector reviewed the home's 'Pain Management Program' and noted that registered staff shall evaluate the resident's response to pain management and this should include the efficacy of the pharmacological intervention. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's #003, #007, and #008 is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview, resident #008 stated that they have not been offered a bath since admission and have only been offered a shower. The resident stated that they inquired about having a bath once and was told by staff that the lift was broken. The resident stated that they have never bothered to ask again because they thought they were not allowed to have a bath. Additionally, the resident stated that they have missed a few showers because the staff were too busy and that they have refused 1 or 2 showers because they were not feeling well.

The inspector reviewed the resident's plan of care. The resident's care plan indicated that the resident preferred a bath. The flow sheets were reviewed for a period of approximately two months. One month it was documented that the resident had 5 showers, they were not available on 2 occasions, 1 was not identified (bath, shower or sponge bath), and 1 was refused. The next month it was documented that the resident had 6 showers and 1 was refused.

The inspector noticed a memo on a board in the home. The memo outlined that residents are required to have at a minimum of two baths of their choice per week. The memo further indicated that "there are a significant number of residents who did not have a bath during one month or had only one or two baths in December and this is concerning. Also staff have documented that residents are Not Available or the task is Not Applicable which is unacceptable documentation. If a resident refuses to have their bath staff must offer an alternative type of bath or an alternative time for bath, if

the resident refuses the staff must report to the nursing staff. Nursing staff must follow up with residents who are refusing their bath to determine the reason for the refusal and if necessary update the care plan to include a different type of bath, different time or day for bath. If residents are not bathed due to a shortage in staffing on a specific shift the bath must be reassigned to the next day or the next shift.

The inspector interviewed the Administrator regarding bathing of residents. The Administrator stated that PSWs know resident's preferences (bath or shower). The Administrator was not aware of residents not being offered a choice of a bath, shower, or sponge bath. The Administrator stated that they have had some issues working short staffed with PSWs and therefore some resident's baths might have been missed, however the home advised the staff that if they do not have time they need to move the bath to the next day. The Administrator confirmed that both tubs were in working condition. She stated that the tub does not move up and down however the staff use a ceiling lift for residents to get in and out.

The inspector interviewed four staff (S #105, S #112, S #113, and S #114) who all stated that the tub chair had been broken for approximately one year, therefore if residents prefer a bath, staff need to use the ceiling lift with a mesh sling. During an interview, S #112 and S #113 stated that more residents used to have baths as opposed to showers when the tub chair was working and that some residents find the ceiling lift with the sling uncomfortable.

Resident #008 stated that they have never been offered to have a bath using the ceiling lift with sling.

After an interview, one staff member asked the inspector if they should be asking residents' what they prefer before each bath/shower.

Additionally, the inspector reviewed the flow sheets for a period of approximately two months for resident #003 and #007. One month it was documented that resident #003 refused on 2 occasions and the next month it was documented that the resident refused on 3 occasions and there was missing documentation on 1 occasion. The inspector noted that there was no further documentation regarding the reason for refusal or assignment to the next day. For resident #007, in one month it was documented that the resident refused on 1 occasion. The inspector noted that there was no further documentation regarding the reason for refusal or assignment to the next day.

The DOC stated to the inspector that if it is not documented then it was not done. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that each resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items

During a tour of the home, Inspector #575 observed unlabelled personal items in the tub and shower rooms throughout the home. In one of the tub rooms, the inspector noted an unlabelled used razor and several unlabelled conditioner and shampoo. In another tub room there was unlabelled shampoo and body wash. In a shower room there were unlabelled shampoo and body wash.

Approximately one week later, the inspector observed the same items with the presence of the Administrator. The Administrator confirmed that the personal items were not labelled. [s. 37. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure residents are offered an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required.

During an interview with Inspector #594, resident #007 stated that they have some chewing problems. When asked by the inspector if the home had offered a dental assessment, the resident stated not at all.

During an interview with the Inspector #575, resident #002 stated that they had oral health problems.

Inspector #594 interviewed S #101 who stated that residents are not offered an annual dental assessment. The inspector interviewed S #121 who stated they did not know when or by whom residents are offered an annual dental assessment. S #121 stated that another staff told them that residents are offered an annual dental assessment, however S #121 was unable to tell the inspector when residents are asked.

The inspector reviewed the home's 'Oral Care Program' dated August 2013 which stated a dental assessment and preventative services performed by a qualified dental professional shall be offered to the residents annually and that the Administrator will arrange for annual preventative services.

Inspector #594 reviewed the admission progress notes and noted that it failed to identify that resident #007 was offered an annual dental assessment.

Inspector #575 reviewed the resident #002's health care record and noted that it that failed to identify that resident #002 was offered an annual dental assessment.

During an interview with the inspector, the Administrator stated they discuss the financial aspect of the admission and that they have never heard of an annual dental assessment and have never been approached to arrange for such services. [s. 34. (1) (c)]

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 ensuring that each resident is offered an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required, to be implemented voluntarily.

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 prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 19 day of June 2015 (A2)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

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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
May 25, 2015;	2015_332575_0004 (A2)	S-000685-15	Resident Quality Inspection

Licensee/Titulaire de permis

WIKWEMIKONG NURSING HOME LIMITED
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

WIKWEMIKONG NURSING HOME
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

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 prévue le Loi de 2007 les foyers de soins de longue durée

GAIL PEPLINSKIE (154) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Review completed and grounds amended in Orders #001, #004 and # 006 as requested by LTC Home.

Issued on this 19 day of June 2015 (A2)

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

Ministère 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

Health System Accountability and Performance Division
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : GAIL PEPLINSKIE (154) - (A2)

Inspection No. / No de l'inspection : 2015_332575_0004 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : S-000685-15 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jun 18, 2015;(A2)

Licensee / Titulaire de permis :
WIKWEMIKONG NURSING HOME LIMITED
2281 Wikwemikong Way, P.O. Box 114,
Wikwemikong, ON, P0P-2J0

LTC Home / Foyer de SLD :
WIKWEMIKONG NURSING HOME
2281 Wikwemikong Way, P.O. Box 114,
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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

Ministère 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 Administrator / Nom de l'administratrice ou de l'administrateur : Cheryl Osawabine-Peltier

To WIKWEMIKONG NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_331595_0004, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

(A2)
The licensee shall prepare, submit and implement a plan for achieving compliance under s. 19 (1) of the LTCHA. The plan is to include but not be limited to:

(1) What interventions will be implemented to monitor resident s #010, #022, #026, #005, #014 to ensure that other residents are protected from abuse;

(2) Strategies to manage resident s #010, #022, #026, #005, #014 abusive behaviours, considering psychological, pharmaceutical, behavioural and physical interventions. Resident responses are to be documented;

(3) Actions to be taken by each discipline to respond to the needs of resident s
#010, #022, #026, #005, #014;

(4) Strategies to protect residents from resident s #010, #022, #026, #005, #014;

(5) A process to ensure that the home s Behavioural Support Program and Critical Incident Policies are followed in that the physician is notified when a resident exhibits responsive behaviours and the police are notified if there was intent to harm;

(6) A process to ensure that when a resident is referred and seen by BSO, staff follow up to receive the report.

.
This plan must be faxed, to the attention of LTCH Inspector Lindsay Dyrda, at
(705) 564-3133. The plan is due on June 8, 2015, with a compliance date of July 6, 2015.

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that resident #010 was protected from abuse by resident #014 in two separate CIs submitted to the MOHLTC over a period of two weeks.

CI #1856-000039-14 identified that in the hallway, resident #010 was struck twice in the face by resident #014 and CI #1856-000001-15 identified that, resident #010 had sustained an injury to the left area of the forehead and was bleeding from an altercation with resident #014.

Inspector #580 reviewed resident #014's health care record which identified that the resident had a history of responsive and abusive behaviours. In addition, the inspector reviewed the progress notes of resident #014 which indicated that from December 28, 2014 to February 21, 2015 there were four further aggressive incidents.

Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with behaviour assessment tools including the antecedent and consequences. Registered staff S #106 confirmed to the inspector that DOS charting is to be completed in hard copy for 72 hours past the incident. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The DOC confirmed to the inspector that DOS charting was not completed on resident #014.

The policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO. A referral was made to BSO on December 29, 2014 for resident #014. The Administrator confirmed to the inspector that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. The DOC confirmed to the inspector that she was not able to find the BSO written report for resident #014.

Inspector #580 reviewed the care plan for resident #014 which indicated that for the goals to a) reduce incidents of verbal physical aggressions to ensure the safety for residents and b) ensure the resident will not strike others, the interventions (created on August 1, 2012) included:

-to move the resident to a quiet area and to remove the resident from public area when in confrontation with others.

-to initiate behavior charting (DOS) to identify why the resident became so angry or agitated and include the time of day, who was present and what preceded the

incident. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #014. This intervention was not implemented.

During interviews, four staff (S #118, S #114, S #105, S #106) confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for the prevention of verbal physical aggression in regard to resident #014.

Inspector #580 reviewed the home's CI policy dated August 2013 which indicated and the Administrator confirmed that when resident to resident abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified after either CI.

As a result, the licensee failed to ensure that resident #010 was protected from abuse by resident #014. (580)

(A2)
2. The licensee has failed to ensure that residents were protected from abuse by resident #005. Two separate CIs were submitted to the MOHLTC over a period of three months during which resident #005 was abusive to two residents (#026 and #022).

Inspector #580 reviewed resident #005's health care record which identified that the resident had a history of responsive and abusive behaviours. In addition, the inspector reviewed the progress notes of resident #005 which indicated that from November 17, 2014 to February 22, 2015, there were three further aggressive incidents.

Inspector #580 reviewed the home's Abuse and Neglect Prevention Program, Appendix A – I, dated November 2014 which included a statement confirming zero tolerance of abuse and the requirement to implement interventions to prevent further abuse. The inspector reviewed resident #005's progress notes which indicated: that the resident was referred to the BSO program on September 24, 2014 and discharged from the program on December 3, 2014, that three more aggressive incidents occurred in the following two months, and that the BSO clinician indicated in the progress notes that a re-referral could be requested. The inspector reviewed the care plan and progress notes and noted no new referral was made to BSO. The

inspector reviewed the North East BSO Intake and Triage Form completed September 24 2014; the October 31 2014 consult from a physician with the Geriatric Medicine Associates of the Hamilton Health Sciences prescribing medication to deal with the violent behaviour but apologizing that they could not be more helpful and hoped that BSO might help staff deal with the resident's very difficult outbursts.

Inspector #580 reviewed the care plan interventions of resident #005 which indicated that for the goal to not harm others, DOS charting was to be active and charted on every hour (created October 23, 2014), that a congestion of hallways was to be avoided (created March 10, 2011), and that the resident was to be reminded to ask staff to move other residents to ensure pathway clear (created March 10, 2011). The care plan intervention for the goal to reduce episodes of aggression indicated that DOS charting is to be active and charted every hour (created October 23, 2014). The care plan intervention for the goal to reduce incidents of agitated behaviour, was to be careful of not invading the resident's personal space (created March 25, 2014) and DOS charting is to be active and charted every hour (created October 23, 2014). These interventions were not implemented related to CI #1856-000038-14 and CI #1856-000027-14, nor in the three other incidents of aggression between November 17, 2014 and February 22, 2015.

During interviews, three staff (S #105, S #118, S #114) confirmed to the inspector that they did not know what responsive behaviour interventions the care plan or kardex indicated for resident #005.

Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with behaviour assessment tools including the antecedent and consequences. Registered staff S #106 confirmed to Inspector #580 that DOS charting is to be completed in hard copy for 72 hours past the incident. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The DOC confirmed to the inspector that DOS charting was not completed on resident #005.

The policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO who are onsite at the home monthly. The Administrator confirmed to the inspector that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not

work. The DOC confirmed to the inspector that BSO completes assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart, but the DOC was not able to find any BSO referral for resident #005 after his discharge from the BSO program on December 3, 2014.

Additionally, the policy indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes. The physician was not notified for CI #1856-000038-14.

Inspector #580 reviewed the home's CI policy dated August 2013, which indicated, and the Administrator confirmed, that when resident to resident abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified for CI #1856-000027-14 or CI #1856-000038-14.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, Inspector #580 identified that interventions were not implemented to prevent physical abuse, that staff were not aware of the interventions in place, that the physician was not notified after CI #1856-000038-14 to determine if there were further resident actions required and to rule out medical and physiological causes and that the police were not notified.

As a result, the licensee failed to ensure that resident #026 and resident #022, were protected from abuse by resident #005. (580)

(A2)
3. The licensee has failed to ensure that residents were protected from abuse by resident #026 in four separate CIs submitted to the MOHLTC over a period of six months during which resident #026 was abusive to four residents (#005, #010, #021, and #022).

Inspector #580 reviewed resident #026's health care record which identified that the resident had a history of responsive and abusive behaviours. In addition, the inspector reviewed the progress notes of resident #026 which indicated that from August 15, 2014 to February 5, 2015, there were three further aggressive incidents.

Inspector #580 reviewed the home's Abuse and Neglect Prevention Program, Appendix A – I, dated November 2014 which included a statement confirming zero tolerance of abuse and the requirement to implement interventions to prevent further abuse. The inspector reviewed resident #026's progress notes which indicated that the resident was discharged from the BSO program on December 3, 2014 following five aggressive incidents in four months, that two more aggressive incidents occurred in the following two months, and that the BSO clinician indicated in the progress notes that a re-referral could be done at any time and that the home just needed to call the clinician. The inspector reviewed the care plan and progress notes and noted no new referral was made to BSO.

Inspector #580 reviewed the home's CI policy dated August 2013, which indicated that the home would submit required reports to the Director and that any modifications and or updates to the CIs can be made within 10 days of initiating the form. On August 11, 2014 the MOHLTC requested the home amend CI #1856-000013-14 submitted on July 13, 2014 to provide further information. On November 14, 2014 the MOHLTC requested the home amend CI #1856-000028-14 submitted on September 25, 2014 to provide further information. On February 5, 2015 the inspector reviewed the MOHLTC's CI Reports web site which confirmed that the home had not updated the information requested by the Director for either CI.

The CI policy also indicated, and the Administrator confirmed, that when resident to resident abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified for any of the four submitted CIs.

Inspector #580 reviewed the care plan of resident #026 which indicated that for the goals to reduce incidents of aggression and angry outburst and to ensure safety for residents, the interventions included:

a) If the resident begins to act aggressively toward other residents, remove them from the situation and redirect them to other activities (created September 25, 2014);

b) Identify and remove any stimuli that may be adding to stress, move other residents away(created October 24, 2014).

The care plan of resident #026 also indicated to ensure DOS charting was active.

This intervention was not implemented.

Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with behaviour assessment tools including the antecedent and consequences. Registered staff S #106 and confirmed to Inspector #580 that DOS charting is to be completed in hard copy for 72 hours past the incident. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done.

The policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO who are onsite at the home monthly. The Administrator confirmed to the inspector that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. The DOC confirmed to the inspector that BSO completes assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart, but the DOC was not able to find any BSO referral for resident #026.

The home's policy further indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes. The physician was not notified for CI #1856-000036-14 or CI #1856-000038-14.

During interviews, three staff (S #105, S #118, S #114) confirmed to the inspector that they did not know what responsive behaviour interventions the care plan or kardex indicated for resident #026. Additionally, S #114 stated to the inspector that resident #026 calms down when spoken to in their native language, however this intervention was not included in the care plan.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, Inspector #580 identified that staff were not aware of the interventions in place to prevent physical abuse, that the physician was not notified after CI #1856-000036-14 or CI #1856-000038-14 to determine if there were further resident actions required and to rule out medical and physiological causes and that the police were not notified.

As a result, the licensee failed to ensure that resident s #005, #010, #021, and #022 were protected from abuse by resident #026. (580)

(A2)
4. The licensee has failed to ensure that residents were protected from abuse by resident #022.

A previous compliance order (CO) related to the Long-Term Care Home Act, s. 19 (1) was issued during inspection #2014_331595_0004 with a compliance date of November 1, 2014.

From September 25, 2014 to November 23, 2014, four CIs were reported to the Director related to abuse by resident #022 toward four other residents in the home (#005, #013, #016, and #017). Inspector #580 reviewed resident #022's health care records including the care plan, PCC progress notes, MDS assessments, and POC flow sheets.

The inspector reviewed the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy which identified that when a resident exhibits responsive behaviours, staff are to:

- assess the resident with behaviour assessment tools including antecedent and consequences;
- notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes; and
- make referrals to BSO (the Administrator confirmed to that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. The DOC was not able to find the BSO report for resident #022).

The home confirmed there is zero tolerance of abuse and the requirement to implement interventions to prevent further abuse. The Administrator confirmed that when resident to resident abuse occurs, the staff are trained to call the police if there was intent to harm.

The inspector interviewed staff who reported that:

- DOS charting is completed in hard copy for 72 hours past the incident but that DOS charting did not usually get done and that DOS charting was not completed on resident #022;
-resident #022 used to walk into people when they used a walker;
-resident #022 liked to fight and remembers what they did;
-for a period of time resident #022 could not have a knife or a fork at the dining table because of aggressive behaviours, but the staff were not sure if that intervention was still in place; and
-staff did not know what resident #022's care plan or kardex indicated regarding interventions for responsive behaviours.

The Administrator confirmed that resident #022 was aggressive, but that they were different now (the resident had a fall and is in a wheelchair now), that it helps to keep the resident busy with activity, that when the staff assessed the incidents of aggression they realized they needed activities in the evening, but confirmed there is no record of this plan.

On February 24, 2015 resident #022 confirmed to the inspector that they felt safe in the home and protected, but that they protected themself with their fists and raised their fists to indicate to the inspector that they would punch.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, the inspector identified that staff were not aware of the interventions in place to prevent physical abuse, that the physician was not notified after three CIs to determine if there were further resident actions required and to rule out medical and physiological causes and that the police were not notified.

As a result, the licensee failed to ensure that resident s #005, #013, #016, and #017 were protected from abuse by resident #022. (580)

(A2)
5. The licensee has failed to ensure that residents were protected from abuse by resident #010 in four separate critical incidents (CI) submitted to the Ministry of Health and Long Term Care (MOHLTC) over a period of five months in which resident #010 was abusive to resident #024, resident #026, and resident #014.

i). CI #1856-000030-14 related to a resident assault occurring on September 27, 2014 at 10:54, was reviewed by Inspector #580. According to the CI, a PSW reported that resident #010 was in an altercation with resident #024 (roommate). Resident #010 was observed grabbing resident #024 s t-shirt and punching them in the arm. Staff member S #114 reported that while they were providing a shower to another resident, they overheard resident #010 calling resident #024 names. Staff member S #117 intervened and separated the residents. This incident occurred in the hallway. Subsequent to this incident, resident #024 was moved to another room.

a. The Home's Nursing Consultant confirmed to Inspector #575 that the care plan used by staff is in the home's electronic documentation system – Point Click Care (PCC). Staff member S #107 confirmed to Inspector #580 that PSWs can look at a printed copy of the care plan but mostly they look at PCC's Point Of Care (POC)'s Kardex for care directions. Inspector #580 reviewed resident #010's care plan and found no corresponding focus related to physical aggression on care plan with print date of 02 24 15 and revision date of 10 23 14. The focus read "problematic manner in which resident becomes angry AEB verbal aggression toward staff or roommate". Three staff member s (S #105, S #118, S #114) confirmed to Inspector #580 that they get care directions from the care plan kardex on POC however, S #118, S #105, S #106 confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for prevention of physical aggression in regard to resident #010.

Inspector #580 reviewed resident #010's health care record which identified that the resident had a history of responsive and abusive behaviours. The inspector reviewed the progress notes of resident #010 which indicated that since November 2014 there had been eight aggressive outbursts in addition to the four submitted CI reports.

b. Inspector #580 reviewed the home's Abuse and Neglect Prevention Program, Appendix A – I, dated November 2014 which included a statement confirming zero tolerance of abuse and the requirement of staff to implement interventions to prevent further abuse. The inspector also reviewed the referral made to Behaviour Support Ontario (BSO) on September 24, 2014 and the progress notes that identified the following:

- the BSO Clinician met with resident #010 and family on November 5, 2014;
- the MDS assessment dated November 7, 2014 of behavioural symptoms indicated

that interventions for verbal abusiveness to other residents are in place, effective and new interventions are not required;
- BSO met with resident #010 on November 19, 2014;
- resident #010 was verbally aggressive with another resident on November 16, 21, and 30, 2014;
- BSO met with resident #010 on December 3, 2014 and left a few ideas of activities to complete with the resident;
- resident #010 was yelling at other residents in the hallway on December 14, 2014;
- BSO met with resident #010 on December 21, 2014; and
- resident #010 was yelling at other residents on December 21, 2014.

c. Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes. Resident #010's physician was not notified after CI #1856-000030-14. The policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO who are on site at the home monthly. A referral was made to BSO on September 24, 2014 for resident #010. The Administrator confirmed to Inspector #580 that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. On February 26, 2015 the DOC confirmed to the inspector that she was not able to find the BSO written report for the resident.

d. Inspector #580 reviewed the home's CI policy dated August 2013, which indicated and the Administrator confirmed, that when resident to resident abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified after CI #1856-000030-14.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, Inspector #580 identified that the physician was not notified after CI #1856-000030-14 to determine if there were further resident actions required and to rule out medical and physiological causes and that the police were not notified.

As a result, the licensee failed to ensure that resident #024 was protected from

abuse by resident #010.

ii). CI #1856-000036-14, related to a resident to resident assault occurring on November 12, 2014 at 14:45, was reviewed by Inspector #580. According to the CI, both residents were sitting beside each other in the west-wing lounge when resident #010 became agitated with resident #026 and threw an empty coffee cup at them. The cup struck the resident on the chest. Housekeeping staff S #119 was able to intervene and stopped resident #026 from striking resident #010.

a. Inspector #580 reviewed the care plan of resident #010 which indicated that for the goals to reduce incidents of aggression and striking others (created October 23, 2014), the interventions included:

- removing the resident from public area when behaviour is disruptive and or unacceptable. This intervention was not implemented;

- removing any stimuli that may be adding to this resident's stress (too many people, noise, tub filling, etc.). Resident #010's progress notes about CI #1856-000036-14 indicated that the resident was attending the home's church service with other residents. The care plan intervention of removing any stimuli that may be adding to the stress such as too many people or noise was not implemented;

- moving other residents away, moving other residents out of the area to ensure their safety, ensuring that personal space for the resident is maintained, to give them space and not to crowd them. In CI #1856-000036-14 report, both residents were sitting beside each other the lounge when resident #010 got agitated with resident #026 then threw an empty coffee cup at them. The care plan intervention of ensuring that personal space for the resident is maintained, to give them space and not to crowd them was not implemented;

- initiating behavior mapping -Behaviour Daily Observation Sheet (DOS) after an incident to identify why the resident becomes angry or agitated (note time of day, who was present, and what preceded the incident, once complete review and analyze the data for trends). Registered staff S #101 confirmed that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #010.

b. Inspector #580 reviewed the home's Behavioural Support Program policy dated

August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes. Resident #010's physician was not notified after CI #1856-000036-14.

c. Inspector #580 reviewed the home's CI policy dated August 2013 which indicated and the Administrator confirmed, that when resident to resident abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified after CI #1856-000036-14.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, Inspector #580 identified that interventions to prevent further abuse were not implemented, that the physician was not notified after CI #1856-000036-14 to determine if there are further resident actions required and to rule out medical and physiological causes and that the police were not notified.

As a result, the licensee failed to ensure that resident #026 was protected from abuse by resident #010.

iii). CI #1856-000039-14 related to a resident to resident assault occurring on December 28, 2014 at 07:45, was reviewed by Inspector #580. According to the CI, a PSW reported that resident #014 hit resident #010 twice in the face in hallway. There was some yelling overheard by both residents prior to the incident. Resident #014 claimed that resident #010 initiated the incident. Subsequent to the incident, a BSO referral was made for resident #014 and BSO visited the resident on January 19, 2015. Resident #010 was being followed by BSO.

a. Inspector #580 reviewed the care plan of resident #010 which indicated that for the goals to reduce incidents of aggression and striking others (created October 23, 2014), the interventions included:

- remove from public area when behaviour is disruptive and or unacceptable. CI #1856-000039-14 indicated that resident #010 was yelling at resident #014 in a public hallway when the incident occurred.
- removing any stimuli that may be adding to the stress (too many people, noise, tub filling, etc.). Inspector #580 reviewed the care plan of resident #014 which indicated that the resident had socially inappropriate behaviour with disruptive noises, screams

and repetitive verbalizations.
- initiate behavior mapping (DOS) after an incident to identify why the resident becomes angry or agitated (note time of day, who was present, and what preceded the incident), once complete review and analyze the data for trends. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #010.

b. Inspector #580 reviewed the home's CI policy dated August 2013 which indicated and the Administrator confirmed that when resident to resident abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified after CI #1856-000039-14.

Inspector #580 reviewed resident #010's health care record which identified that the resident had an extensive history of responsive and abuse behaviours. After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, Inspector #580 identified that interventions to prevent further abuse were not implemented and that the police were not notified.

As a result, the licensee failed to ensure that resident #014 was protected from abuse by resident #010.

iv). CI #1856-000001-15 related to a resident to resident assault occurring on January 10, 2015 at 15:20, was reviewed by Inspector #580. According to the CI, two residents were yelling at each other in the hallway; resident #014 was holding the phone receiver above their head and resident #010 had sustained an injury to the left area of the forehead and was bleeding. Resident #014 stated that resident #010 would not leave them alone; resident #010 stated that resident #014 bumped them on the head, that they did not like the other resident, that they wanted to do the same to resident #014 and they did not want to stay in the nursing home anymore. A BSO referral was made for resident #014 and BSO visited the resident on January 19, 2015.

a. Inspector #580 reviewed the care plan of resident #010 which indicated that for the goal to reduce incidents of aggression (created October 23, 2014) and the resident will not strike others (created October 23, 2014), the interventions included:

- removing from public area when behaviour is disruptive and or unacceptable.

- removing any stimuli that may be adding to the stress (too many people, noise, tub filling, etc.). Inspector #580 reviewed the care plan of resident #014 which indicated that the resident had socially inappropriate behaviour with disruptive noises, screams and repetitive verbalizations.
- moving other residents away, move other residents out of the area to ensure their safety. Ensure to maintain personal space for the resident. Do not crowd them, give them space.
- initiating behavior mapping (DOS) after an incident to identify why the resident becomes angry or agitated (note time of day, who was present, and what preceded the incident, once complete review and analyze the data for trends. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #010.

b. Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes. Resident #010's physician was not notified after CI #1856-000001-15.

c. Inspector #580 reviewed the home's CI policy dated August 2013 which indicated and the Administrator confirmed that when resident to resident abuse occurs, the staff are trained to call the police if there was intent to harm. The police were not notified after CI #1856-000001-15.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program, CI Policy and Behaviour Support Policy, Inspector #580 identified that interventions to prevent further abuse were not implemented, that the physician was not notified after CI #1856-000001-15 to determine if there are further resident actions required and to rule out medical and physiological causes, and that the police were not notified.

As a result, the licensee failed to ensure that resident #014 was protected from abuse by resident #010. (580)

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

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

Ministère 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

Jul 06, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #010.

Inspector #594 reviewed resident #010's health care record which identified the resident as incontinent of bladder. The plan of care was reviewed by the inspector which stated that the resident was continent of bladder.

Inspector #594 interviewed three staff (S #102, S #103, and S #104) who all stated that the resident was incontinent of bladder. Upon review of the resident's care plan, S #104 verified the care plan stated the resident was continent.
(594)

2. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to resident #009.

Inspector #594 reviewed the resident health care record which stated no bed rails are used by the resident. The inspector observed the resident throughout the inspection with two quarter bed rails in use.

A review of the care plan by the inspector failed to identify the use of any bed rails. Inspector #594 interviewed S #100 who stated that two quarter bed rails were in use for mobility and it would be identified in the kardex, which is accessible by direct care staff. The inspector interviewed S #101 who stated that the use of bed rails are to be documented in the care plan and stated that resident #009's bed rails are just up, and not for any purpose. Upon review of the care plan, S #101 stated that the care plan failed to identify the use of any bed rails.

In addition, the Bed Rail Risk Assessment completed for resident #009 stated no bed rails are recommended. Inspector #594 reviewed the home's policy titled 'Resident Safety 3.4 Bed Rails' dated July 07, 2012 and noted the policy indicated the use of bed rails should be documented clearly.
(594)

3. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to resident #006.

Inspector #594 reviewed the resident's health care record which stated that no bed rails are used by the resident. The inspector observed the resident throughout the inspection with one quarter bed rail in use. During an interview with the inspector, resident #006 stated that one quarter bed rail is always in use.

A review of the resident's care plan by the inspector failed to identify bed rail use. Inspector #594 interviewed S #100 who stated that the resident required two quarter bed rails and would be identified in the kardex, which is accessible by direct care staff. The inspector interviewed S #101 who stated that the use of bed rails are to be documented in the resident's care plan and stated that resident #006 required one quarter bed rail. Upon review of the care plan, S #101 stated that the care plan failed to identify the use of any bed rails.

In addition, the Bed Rail Risk Assessment completed for resident #006 recommended one full length bed rail. Inspector #594 reviewed the home's policy titled 'Resident Safety 3.4 Bed Rails' dated July 07, 2012 and noted the policy indicated the use of bed rails should be documented clearly. (594)

4. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to resident #005.

Inspector #594 reviewed the resident's health care record which stated that resident #005 required total support for transferring and toileting. The inspector reviewed the care plan for the resident which stated that the resident required a two person assist for toileting and a one person extensive assistance for transferring.

The inspector interviewed S #100 who stated that the resident required two person assist for both transferring and toileting. The inspector interviewed S #101 who stated that the resident required one person assist. Upon review of the care plan, S #101 stated that the care plan does not give any direction for the number of staff required to assist the resident.
(594)

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

Jun 19, 2015

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

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

Ministère 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

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the home's Behavioural Support Program policy is complied with including the following:

(1) Staff assess residents who display responsive behaviours including the antecedent and consequences; and

(2) DOS charting is completed for 72 hours after an incident.

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

Ministère 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

Grounds / Motifs :

1. The licensee has failed to ensure that the home's policy titled 'Behavioural Support Program' dated August 2013 is complied with.

Inspector #580 reviewed the home's policy titled 'Behavioural Support Program' dated August 2013. The policy indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with the assessment tools to track behaviour, including antecedent and consequences. The policy further indicated behaviour documentation should be completed for a seven day period.

The inspector interviewed the S #106 who stated that the DOS charting is completed in hard copy for 72 hours after an incident of responsive behaviours. During an interview S #101 stated that DOS charting did not usually get done.

The inspector reviewed the health care records for eight residents who displayed responsive behaviours (#005, #010, #013, #014, #015, #020, #022, #026). The DOC confirmed to the inspector that DOS charting was not completed for any of the eight residents. (580)

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

Jun 08, 2015

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan for achieving compliance under s. 6 (7) of the LTCHA, ensuring that the care set out in the plan of care is provided to resident #005, #010, #014, and #022.

This plan must be faxed, to the attention of LTCH Inspector Lindsay Dyrda, at
(705) 564-3133. The plan is due on June 8, 2015, with a compliance date of July 6, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #014 as specified in the plan.

Two separate CIs submitted to the MOHLTC over a period of two weeks, identified that resident #014 was abusive to resident #010. In both incidents, the interventions were not provided as specified in the plan of care.

Inspector #580 reviewed the care plan of resident #014 which indicated that for the goals to a) reduce incidents of verbal/physical aggressions to ensure the safety for residents and b) ensure the resident will not strike others, the interventions included:

-to move the resident to a quiet area; to remove the resident from public area when in confrontation with others. In both CIs, the resident was in the hallway with other residents, and the interventions were not implemented;

-to initiate behavior charting (DOS) to identify why the resident became so angry or agitated and include the time of day, who was present and what preceded the incident. Registered staff S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #014. This intervention was not implemented.

During interviews, four staff (S #118, S #114, S #105, S #106) confirmed to the inspector that they do not know what the care plan or kardex indicated for the prevention of verbal/physical aggression in regard to resident #014.

Throughout the inspection period, inspector #580 observed resident #014 seated in the crowded hallways.

After interviews with staff, review of the resident's care plan and progress notes Inspector #580 identified that even though, resident #014 had a history of behaviours, care plan interventions to prevent further abuse by resident #014 were not implemented.

As a result, the licensee failed to ensure that the care set out in the plan of care was provided to resident #014 as specified in the plan. (580)

(A2)
2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

Two separate CIs submitted to the MOHLTC over a period of three months identified that resident #005 was abusive to two residents (#026 and #022). In both incidents, the interventions were not provided as specified in the plan of care.

Inspector #580 reviewed the care plan interventions for resident #005 which indicated that for the goal to not harm others, DOS charting was to be active and charted on every hour (created October 23, 2014), that a congestion of hallways was to be avoided (created March 10, 2011), and that the resident was to be reminded to ask staff to move other residents to ensure pathway clear (created March 10, 2011). The care plan intervention for the goal to reduce episodes of aggression indicated that DOS charting is to be active and charted every hour (created October 23, 2014). The care plan intervention for the goal to reduce incidents of agitated behaviour indicated to be careful of not invading the resident's personal space (created March 25, 2014) and DOS charting is to be active and charted every hour (created October 23, 2014). The interventions were not implemented regarding either CI, or in the three other incidents of aggression between November 17, 2014 and February 22, 2015.

Three staff (S #105, S #118, S #114) confirmed to the inspector that they did not know what responsive behaviour interventions the care plan or kardex specified for resident #005.

Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with behaviour assessment tools including antecedent and consequences. Registered S #106 confirmed to Inspector #580 that DOS charting is to be completed in hard copy for 72 hours past the incident. Registered S #101 confirmed to Inspector #580 that DOS charting did not usually get done. The BSO policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO who are onsite at the home monthly. The Administrator confirmed to Inspector #580 that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. The DOC confirmed to the inspector that BSO completes

assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart, but the DOC was not able to find any BSO referral for resident #005.

After interviews with staff, review of the resident's care plan and progress notes Inspector #580 identified that care plan interventions to prevent further abuse were not implemented.

As a result, the licensee failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan. (580)

(A2)
3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #026 as specified in the plan.

In four separate CIs were submitted to the MOHLTC over a period of six months during which resident #026 was abusive to four residents (#005, #010, #021, and #022). In all the incidents, the interventions were not provided as directed in resident #026's plan of care.

Inspector #580 reviewed the care plan for resident #026 which indicated that for the goals to reduce incidents of aggression and angry outbursts and to ensure safety for residents, the interventions included:

a) If the resident begins to act aggressively toward other residents, remove him from the situation and redirect him to other activities;

b) Identify and remove any stimuli that may be adding to stress, move other residents away.

The care plan for resident #026 also indicated that for the goals to reduce incidents of aggression and angry outburst, to ensure safety for resident(s) (created July 9, 2014), the interventions included to ensure DOS charting was active. This intervention was not implemented.

As a result, the licensee failed to ensure that the care set out in the plan of care was provided to resident #026 as specified in the plan. (580)

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #022 as specified in the plan.

In four separate CIs submitted to the MOHLTC over a period of three months in which resident #022 was abusive to resident's #005, #013, #016, and #017. Resident #022's plan of care identified interventions to prevent abusive behaviours, however, in all the incidents the interventions were not provided as directed in the plan of care. (580)

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #010 as specified in the plan.

In four separate CIs submitted to the MOHLTC over a period of five months resident #010 was abusive to resident's #024, #026, and #014. Resident #010's the plan of care identified interventions to prevent abusive behaviours, however, in all four of the incidents the interventions were not provided as directed in the plan of care.

During an interview, S #120 confirmed to Inspector #575 that the care plan used by staff is in the home's electronic documentation system – PCC. Registered S #107 confirmed to Inspector #580 that PSWs can look at a printed copy of the care plan but mostly they look at PCC's POC kardex for care directions. Three staff (S #105, S #118, S #114) confirmed to Inspector #580 that they get care directions from the care plan/kardex on POC, however, S #118, S #105, S #106 confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for prevention of physical aggression in regard to resident #010.

Inspector #580 reviewed resident #010's health care record which identified that the resident had a history of behaviours and that over a period of approximately three months there had been eight behaviour incidents in addition to the four submitted CI reports.

Inspector #580 reviewed the care plan of resident #010 which indicated interventions related to behaviours that included:

- initiating behavior mapping (DOS) after an incident to identify why the resident

becomes angry or agitated (note time of day, who was present, and what preceded the incident, once complete review and analyze the data for trends). Registered staff S #101 confirmed that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #010;

- moving other residents away, moving other residents out of the area to ensure their safety, ensuring that personal space for the resident is maintained, to give them space and not to crowd them. In one CI, both residents were in the hallway. In another CI, both residents were sitting beside each other when resident #010 was in an altercation with resident #026;

- remove from public area when behaviour is disruptive and/or unacceptable. One CI indicated that resident #010 was verbally abusive to resident #014 in a public area when the incident occurred;

- removing any stimuli that may be adding to the stress. Resident #010's progress notes about one CI indicated that the resident was attending an activity with other residents. The care plan intervention of removing any stimuli that may be adding to the resident's stress was not implemented.

After interviews with staff, review of the resident's care plan and progress notes, Inspector #580 identified that care plan interventions to prevent further abuse were not implemented.

As a result, the licensee failed to ensure that the care set out in the plan of care was provided to resident #010 as specified in the plan. (580)

6. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #010 as specified in the plan.

On three separate occasions, Inspector #594 observed resident #010 without the chair alarm attached when in their wheelchair.

Inspector #594 reviewed resident #010's care plan which identified that a chair alarm was to be attached when the resident was in their wheelchair and to apply a seat belt

Inspector #594 interviewed S #117 who stated that they were familiar with the resident's care but did not assist the resident with care that morning. When asked by the inspector if the resident required a chair alarm, S #117 stated it would be in the care plan and questioned the inspector if a chair alarm was on the resident's care plan. (594)

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

Jul 06, 2015

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

4. Misuse or misappropriation of a resident's money.

5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006.

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

Ministère 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

Grounds / Motifs :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred immediately reported the suspicion and the information upon which it is based to the Director.

Inspector #580 reviewed the home's CI policy dated August 2013 which indicated that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately be reported to the MOHLTC.

During an interview, the Administrator confirmed to Inspector #580 that when resident to resident abuse occurs, the home is to immediately submit a CI report to the MOHTLC. The Administrator also confirmed that the following four CIs were not submitted immediately to the Director, even though they were notified right away:

CI #1 was submitted eight days after the incident;

CI #2 was submitted five days after the incident;

CI #3 was submitted two days after the incident; and

CI #4 was submitted two days after the incident. (580)

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

Jun 01, 2015

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

Ministère 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

Order # / 006
Ordre no :

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

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 :

(A2)
The licensee shall prepare, submit and implement a plan for achieving compliance with O. Reg. 79 10, s. 53 (4). b., and s. 54 (4). c.

The plan is to include but not be limited to:

(1) A process to monitor resident #005, #010, #014, #022, #026 s and all other residents demonstrating responsive behaviours in the home;

(2) What actions will be taken in order to manage resident #005, #010, #014, #022, #026 s responsive behaviours, including assessments, reassessments, and interventions. In the event there is no change or improvement, alternative interventions and or processes are to be identified;

(3) Responsibilities of each discipline in the management of resident #005, #010, #014, #022, #026 s responsive behaviours, and any other resident demonstrating responsive behaviours, are to be identified;

(4) A process to document resident #005, #010, #014, #022, #026 s responses to interventions, and any other resident receiving interventions for responsive behaviours.

The plan must be faxed, to the attention to LTCH Inspector Lindsay Dyrda at (705)-564-3133. The plan is due on June 8, 2015 with a compliance date of July 6, 2015.

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that for resident #026 who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours, and actions were taken to respond to the needs of the resident including assessment, reassessments and interventions.

Four separate CIs (#1856-000013-14, CI #1856-000028-14, CI #1856-000036-14, CI #1856-000038-14) were submitted to the MOHLTC over a period of three months in which resident #026 was abusive to resident #005, #010,#021, and #022. Resident #026's health care record identified that the resident had a history of responsive and abusive behaviours. In addition, the inspector reviewed the progress notes of

resident #026 which indicated that from August 15, 2014 to February 5, 2015, there were three other aggressive outbursts that did not incur CI reporting.

During an interview, S #106 confirmed to Inspector #580 that DOS charting is to be completed in hard copy for 72 hours past the incident. Another staff (S #101) confirmed to Inspector #580 that DOS charting did not usually get done. The DOC confirmed to the inspector that DOS charting was not completed on resident #026 as indicated in the home's Behavioural Support Program policy.

The inspector reviewed resident #026's progress notes which indicated the resident was discharged from the BSO program on December 3, 2014 following five aggressive incidents in four months, that two more aggressive incidents occurred in the following two months, and that the BSO clinician indicated in the progress notes that a re-referral could be done at any time and that the home just needed to call the clinician. The inspector reviewed the care plan and progress notes and noted no new referral was made to BSO as indicated.

The Administrator confirmed to the inspector that BSO made recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. The DOC confirmed to the inspector that BSO completes assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart, but the DOC was not able to find any BSO referral for resident #026 as indicated by home's Behavioural Support Program policy for behaviour interventions.

Resident #026's physician was not notified for CI #1856-000036-14 and CI #1856-000038-14 as indicated in the home's Behavioural Support Program policy.

Inspector #580 reviewed the care plan of resident #026 which indicated that for the goals to reduce incidents of aggression and angry outburst and to ensure safety for residents, the interventions included:

a) If the resident begins to act aggressively toward other residents, remove them from the situation and redirect them to other activities (created September 25, 2014);

b) Identify and remove any stimuli that may be adding to stress, move other residents away (created October 24, 2014).

The care plan of resident #026 also indicated to ensure DOS charting was active. This intervention was not implemented.

Three staff (S #105, S #118, S #114) confirmed to the inspector that they did not know what responsive behaviour interventions the care plan or kardex indicated for resident #026. During an interview, S #114 stated to the inspector that resident #026 calms down when spoken to in Ojibway, however, this intervention was not included in the care plan.

In the four separate CIs submitted to the MOHLTC over a period of six months during which resident #026 was abusive to four residents, interventions were not provided as directed in resident #026's plan of care.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program and Behaviour Support Policy, Inspector #580 identified that strategies were not implemented to respond to the responsive behaviours as identified in resident #026's care plan and actions stated in the home's policies and listed in resident #026's care plan were not taken to respond to the needs of the resident including assessments, reassessments and interventions. (580)

2. The licensee has failed to ensure that for resident #022 who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours and actions were taken to respond to the needs of the resident including assessments, reassessments and interventions.

Four separate CIs were submitted to the MOHLTC over a period of three months in which resident #022 was abusive to resident's #005, #013, #016, and #017. Resident #022's health care record identified that the resident has a history of behaviours. Also, the inspector reviewed the progress notes of resident #022 which indicated that for a period of approximately three months, there were eight aggressive outbursts that did not incur CI reporting.

During an interview, S #106 confirmed to the inspector that DOS charting is to be completed in hard copy for 72 hours past the incident. Another staff S #101

confirmed to the inspector that DOS charting did not usually get done. S #121 confirmed to the inspector that DOS charting was not completed for resident #022 as indicated by the home's Behavioural Support Program policy for behaviour interventions.

The Administrator confirmed that resident #022 was aggressive, that it helped to keep the resident busy with activity, that when the staff assessed the incidents of aggression they realized they needed activities in the evening, but confirmed there is no record of this plan.

The Administrator confirmed to Inspector #580 that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. S #121 confirmed to the inspector that BSO sends written reports to the home's behaviour referrals and that these reports are placed in the resident's chart, but S #121 was not able to find the BSO report for resident #022 as indicated by home's Behavioural Support Program policy for behaviour interventions.

Resident #022's physician was not notified after one of the CIs as indicated in the home's Behavioural Support Program policy.

Inspector #580 reviewed the care plan of resident #022 which indicated interventions related to behaviours that included:

a) Move them to a quiet area as they are physically aggressive in noisy overcrowded situations and when they feel threatened by other residents. This intervention was not implemented. One CI indicated that resident #022 was sitting in the lounge;

b) Move them to a quiet area and try to divert their attention. This intervention was not implemented. One CI indicated that resident #022 was sitting in the lounge; and

c) Keep resident active in the morning and encourage rest periods after lunch. This intervention was not implemented.

Four staff (S #105, S #118, S #114, S #106) confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for the prevention of aggression in regard to resident #022. In four different CIs submitted to the MOHLTC over a period of three months during which resident #022 was abusive to four residents and

the plan of care identified interventions to prevent abusive behaviours, however, in all the incidents the interventions were not provided as directed in the plan of care.

Throughout the inspection period, inspector #580 observed resident #022 seated near other residents. During an interview, resident #022 confirmed to the inspector that they felt safe in the home and protected, but that they protected themselves with their fists and raised their fists to indicate to the inspector that they would punch.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program and Behaviour Support Policy, Inspector #580 identified that strategies were not implemented to respond to the responsive behaviours as identified in resident #022's care plan, and actions stated in the home's policies and listed in resident #022's care plan were not taken to respond to the needs of the resident including assessments, reassessments and interventions. (580)

(A2)
3. The licensee has failed to ensure that for resident #014 who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours and actions were taken to respond to the needs of the resident including assessments, reassessments and interventions.

Two separate CIs (#1856-000039-14 and #1856-000001-15) were submitted to the MOHLTC over a period of two weeks during which resident #014 was abusive to resident #010. Inspector #580 reviewed resident #014's health care record which identified that the resident had a history of responsive and abusive behaviours. In addition, the inspector reviewed the progress notes of resident #014 which indicated that from December 28, 2014 to February 21, 2014, there were four further aggressive incidents that did not incur CI reporting.

During an interview, S #106 confirmed to the inspector that DOS charting is to be completed in hard copy for 72 hours past the incident. Another staff (S #101) confirmed to the inspector that DOS charting did not usually get done. The DOC confirmed to the inspector that DOS charting was not completed on resident #014 as indicated by the home's Behavioural Support Program policy for behaviour interventions.

The Administrator confirmed to the inspector that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention has already been tried and did not work. The DOC confirmed to the inspector that BSO completes assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart, but the DOC was not able to find the BSO written report for resident #014 as indicated by home's Behavioural Support Program policy for behaviour interventions.

Inspector #580 reviewed the care plan for resident #014 which indicated that for the goals to a) reduce incidents of verbal physical aggressions to ensure the safety for residents and b) ensure the resident will not strike others, the interventions (created on August 1, 2012) included:

-to move the resident to a quiet area; to remove the resident from public area when in confrontation with others: In both CIs, the resident was in the hallway with other residents.;

-to initiate behavior charting (DOS) to identify why the resident became so angry or agitated and to include the time of day, who was present and what preceded the incident. S #101 confirmed to Inspector #580 that DOS charting does not usually get done. The inspector was not able to locate DOS charting for resident #014. The interventions were not implemented related to CI #1856-000039-14 and CI #1856-000001-15, nor in the four other incidents of aggression between December 28, 2014 and February 21, 2014.

Four staff (S #105, S #118, S #114, S #106) confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for the prevention of verbal physical aggression in regard to resident #014.

Throughout the inspection period, inspector #580 observed resident #014 seated in crowded hallways.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program and Behaviour Support Policy, Inspector #580 identified that strategies were not implemented to respond to the responsive and aggressive behaviours as identified in resident #014's care plan, and actions stated in the home's policies and listed in resident #014's care plan were

not taken, to respond to the needs of the resident #014 including assessments, reassessments and interventions. (580)

(A2)
4. The licensee has failed to ensure that for resident #010 who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours and actions were taken to respond to the needs of the resident including assessments, reassessments and interventions.

Four separate CIs (#1856-000030-14, #1856-000036-14, #1856-000039-14, #1856-000001-15) were submitted to the MOHLTC over a period of five months during which resident #010 was abusive to three residents (#014, #024 and #026). Inspector #580 reviewed resident #010's health care record which identified that the resident had a history of responsive and abusive behaviours. In addition, the inspector reviewed the progress notes of resident #010 which indicated that from November 15, 2014 to February 21, 2015, there were eight further aggressive incidents in addition to the four submitted CI reports.

During an interview, S #106 confirmed to the inspector that DOS charting is to be completed in hard copy for 72 hours past the incident. Another staff (S #101) confirmed to the inspector that DOS charting did not usually get done. The DOC confirmed to the inspector that DOS charting was not completed on resident #010, contrary to interventions listed in the home's Behavioural Support Program policy.

Resident #010's physician was not notified after CI #1856-000030-14, contrary to interventions indicated in the home's Behavioural Support Program policy.

A referral was made to BSO on September 24, 2014 for resident #010. The Administrator confirmed to Inspector #580 that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. On February 26, 2015 the DOC confirmed to the inspector that she was not able to find the BSO written report for the resident, contrary to interventions listed in the home's Behavioural Support Program policy.

Inspector #580 reviewed the care plan of resident #010 which indicated that for the goals to reduce incidents of aggression and striking others (created October 23,

2014), the interventions included:

- removing the resident from public area when behaviour is disruptive and or unacceptable. This intervention was not implemented;

- removing any stimuli that may be adding to this resident's stress (too many people, noise, tub filling, etc.). Resident #010's progress notes about CI #1856-000036-14 indicated that the resident was attending the home's church service with other residents. The care plan intervention of removing any stimuli that may be adding to the stress such as too many people or noise was not implemented;

- moving other residents away, moving other residents out of the area to ensure their safety, ensuring that personal space for the resident is maintained, to give them space and not to crowd them. In CI #1856-000036-14 report, both residents were sitting beside each other the lounge when resident #010 got agitated with resident #026 then threw an empty coffee cup at them. The care plan intervention of ensuring that personal space for the resident is maintained, to give them space and not to crowd them was not implemented;

- initiating behavior mapping (DOS) after an incident to identify why the resident becomes angry or agitated (note time of day, who was present, and what preceded the incident, once complete review and analyze the data for trends). Registered staff S #101 confirmed that DOS charting did not usually get done. The inspector was not able to locate DOS charting for resident #010.

The Home's Nursing Consultant confirmed to Inspector #575 that the care plan used by staff is in the home's electronic documentation system – PCC. S #107 confirmed to Inspector #580 that PSWs can look at a printed copy of the care plan but mostly they look at PCC POC's Kardex for care directions. Three staff (S #105, S #118, S #114) confirmed to Inspector #580 that they get care directions from the care plan kardex on POC however S #118, S #105, and S #106 confirmed to Inspector #580 that they did not know what the care plan or kardex indicated for prevention of physical aggression in regard to resident #010.

Throughout the inspection period, inspector #580 observed resident #010 seated in crowded hallways and lounge areas.

After interviews with staff, review of the resident's care plan and progress notes,

review of the home's Abuse and Neglect Prevention Program and Behaviour Support Policy, Inspector #580 identified that strategies were not implemented to respond to the responsive behaviours listed in resident #010's care plan, and actions stated in the home's policies and listed in resident #010's care plan, were not taken, to respond to the needs of the resident #010 including assessments, reassessments and interventions. (580)

(A2)
5. The licensee has failed to ensure that for resident #005 who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours, and actions were taken to respond to the needs of the resident including assessments, reassessments and interventions.

Two separate CIs (#1856-000038-14 and #1856-000027-14) were submitted to the MOHLTC over a period of three months during which resident #005 was abusive to two residents (#026 and #022). Inspector #580 reviewed resident #005's health care record which identified that the resident had a history of responsive and abusive behaviours. In addition, the inspector reviewed the progress notes of resident #005 which indicated that from November 17, 2014 to February 22, 2015, there were three further aggressive incidents that did not incur CI reporting.

Inspector #580 reviewed the home's Abuse and Neglect Prevention Program, Appendix A – I, dated November 2014 which included requirement to implement interventions to prevent further abuse. The inspector reviewed resident #005's progress notes which indicated that the resident was referred to the BSO program on September 24, 2014 and discharged from the program on December 3, 2014, that three more aggressive incidents occurred in the following two months, and that the BSO clinician indicated in the progress notes that a re-referral could be requested. The inspector reviewed the care plan and progress notes and noted no new referral was made to BSO.

Inspector #580 reviewed the home's Behavioural Support Program policy dated August 2013 which indicated that when a resident exhibits responsive behaviours, staff are to assess the resident with behaviour assessment tools including the antecedent and consequences. Registered staff S #106 the confirmed to the inspector that DOS charting is to be completed in hard copy for 72 hours past the incident. Registered staff S #101 confirmed to the inspector that DOS charting did

not usually get done.

The policy also indicated that when a resident exhibits responsive behaviours, staff are to make referrals to BSO who are onsite at the home monthly. The Administrator confirmed to the inspector that BSO makes recommendations to the home but that the reports are slow to come and the recommendations are often no longer relevant as the situation had changed or the intervention had already been tried and did not work. The DOC confirmed to the inspector that BSO completes assessments and sends recommendations in written reports in response to the home's behaviour referrals and that these reports are placed in the resident's chart, but the DOC was not able to find any BSO referral for resident #005 after his discharge from the BSO program on December 3, 2014.

Additionally, the policy also indicated that when a resident exhibits responsive behaviours, staff are to notify the physician to determine if there are further resident actions required and to rule out medical and physiological causes. The physician was not notified for CI #1856-000038-14.

Inspector #580 reviewed the care plan interventions of resident #005 which indicated that for the goal to not harm others, DOS charting was to be active and charted on every hour (created October 23, 2014), that a congestion of hallways was to be avoided (created March 10, 2011), and that the resident was to be reminded to ask staff to move other residents to ensure pathway clear (created March 10, 2011). The care plan intervention for the goal to reduce episodes of aggression indicated that DOS charting is to be active and charted every hour (created October 23, 2014). The care plan intervention for the goal to reduce incidents of agitated behaviour was to be careful of not invading the resident's personal space (created March 25, 2014) and DOS charting is to be active and charted every hour (created October 23, 2014). The interventions were not implemented related to CI #1856-000038-14 and CI #1856-000027-14, nor in the three other incidents of aggression between November 17, 2014 and February 22, 2015.

After interviews with staff, review of the resident's care plan and progress notes, review of the home's Abuse and Neglect Prevention Program and Behaviour Support Policy, Inspector #580 identified that strategies were not implemented to respond to the responsive behaviours listed in resident #005's care plan, and actions stated in the home's policies and listed in resident #005's care plan were not taken to respond to the needs of the resident #005 including assessments, reassessments and

interventions. (580)

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

Jul 06, 2015

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

Ministère 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

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
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 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
Performance Improvement and Compliance 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 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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 19 day of June 2015 (A2)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : GAIL PEPLINSKIE - (A2)

Service Area Office / Bureau régional de services : Sudbury