Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 14, 2017	2017_599166_0014	010942-17	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE PORT HOPE
360 Croft Street PORT HOPE ON L1A 4K8

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 8 ,9, 2017

Critical Incident, Log #: 010942-17, related to an incident of resident to resident physical abuse was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with Resident #001, Administrator, Acting Director Of Care , Acting Assistant Director of Care, Behaviourial Support Ontario (BSO)staff member, Registered Nurse, Registered Practical Nurse, Activation/Program staff member, and Personal Support Workers (PSW).
During the course of this inspection the inspector reviewed the licensee's investigation documentation and resident #001 and resident #002 clinical records.

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. related to log 010942-17

Critical Incident Report(CIR) was submitted to the Director reporting an incident of resident to resident physical abuse by resident #001 directed towards resident #002.

Review of the CIR documentation indicated a staff member witnessed the incident and immediately intervened. Resident #002 was assessed post incident and had no signs of injury.

Review of clinical documentation, interview with the Director of Care(DOC), and interview with resident #001, indicated resident #001 alleged resident #002 was verbally disruptive and resident #001 wanted to stop resident #002.

During an interview with Inspector #166, resident #001, indicated, it would be funny to use a specific item in order to stop the alleged verbalism of resident #002 , however denied using the specific identified item and denied intent to harm.

During an interview with Inspector #166, BSO staff member, who witnessed the incident, indicated the specific identified item was used to the full extent and she was the staff member who removed the item.

During interviews with Inspector #166, the DOC, RN #100, BSO #101, PSW #102, 104 and RPN #102 indicated resident #001, frequently displays responsive behaviors directed towards other residents.

Review of clinical documentation indicated over an identified period of time, fourty-eight (48) documented incidents of inappropriate responsive behaviours directed towards other residents by resident #001.

Review of resident #001's plan of care related to behaviours indicated the intervention currently in place:
-Resident is to be reminded that this behaviour is very inappropriate.

During interviews with inspector #166, RN #100, RPN #103, PSWs #101, #104 and Activation Aide #102, indicated the primary intervention of reminding resident #001, that these behaviours are unacceptable and requesting resident #001 to stop has not been effective. [s. 6. (11) (b)]

Additional Required Actions:

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

Issued on this 15th day of June, 2017

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : CAROLINE TOMPKINS (166)

Inspection No. / No de l'inspection : 2017_599166_0014

Log No. / Registre no: 010942-17

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jun 14, 2017

Licensee / Titulaire de permis : EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD : EXTENDICARE PORT HOPE
360 Croft Street, PORT HOPE, ON, L1A-4K8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jeff Donovan

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To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall:
1. Review and revise the plan of care for resident #001 as it relates to the planned interventions and strategies to manage the responsive behaviours of this resident.
2. Develop and implement a monitoring tool to ensure the planned, revised interventions and strategies are effective in managing the responsive behaviours of resident #001, with special attention to minimizing risks associated with potential harmful interactions between resident #001 and other residents.
3. Promptly consider different interventions and strategies if the revised plan of care is found to be ineffective in managing the responsive behaviours of resident #001.
4. Ensure that all staff who provide direct care to resident #001 are knowledgeable about the revised plan of care and possess the skills and techniques required to effectively implement the planned interventions and strategies related to the management of responsive behaviours.

Grounds / Motifs :

1. related to log 010942-17

Critical Incident Report(CIR) was submitted to the Director reporting an incident of resident to resident physical abuse by resident #001 directed towards resident #002.

Review of the CIR documentation indicated a staff member witnessed the incident and immediately intervened. Resident #002 was assessed post incident and had no signs of injury.

Review of clinical documentation, interview with the Director of Care(DOC), and interview with resident #001, indicated resident #001 alleged, resident #002 was verbally disruptive and resident #001 wanted to stop resident #002.

During an interview with Inspector #166, resident #001 ,indicated it would be funny to use a specific item in order to stop the alleged verbalism of resident #002 , however denied using the specific identified item and denied intent to harm.

During an interview with Inspector #166, BSO staff member, who witnessed the incident, indicated the specific identified item was used to the full extent and she was the staff member who removed the item.

During interviews with Inspector #166, the DOC, RN #100, BSO #101, PSW #102, 104 and RPN #102 indicated resident #001, frequently displays responsive behaviors directed towards other residents.

Review of clinical documentation indicated over an identified period of time there were fourty-eight(48) documented incidents of inappropriate responsive behaviours directed towards other residents by resident #001.

Review of resident #001's plan of care related to behaviours indicated the primary intervention currently in place:
- Resident is to be reminded that this behaviour is very inappropriate.

During interviews with inspector #166, RN #100, RPN #103, PSWs #101, #104 and Activation Aide #102, indicated the primary intervention of reminding resident #001, that these behaviours are unacceptable and requesting resident #001 to stop has not been effective. [s. 6. (11) (b)]

A Compliance Order will be issued under LTCHA ,2007, s.6.(11)(b), related to the frequency of documented incidents of responsive behaviours involving resident #001 and other residents. The CIR submitted demonstrated an escalation in resident #001's responsive behaviour identifying a potential

serious risk for a negative outcome for both resident #001 and other residents,

(166)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 27, 2017

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 14th day of June, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : CAROLINE TOMPKINS

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