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

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

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

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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
Aug 09, 2016;	2016_205129_0004 (A1)	003711-16	Complaint

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 HALTON HILLS
9 Lindsay Court Georgetown ON L7G 6G9

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

PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Issued on this 9 day of August 2016 (A1)

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

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PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): February 25, 26, 29, March 3, and 8, 2016

Log #003711-16 related to possible discharge of the resident and care of the resident demonstrating responsive behaviours

During the course of the inspection, the inspector(s) spoke with the resident's substitute decision maker (SDM), family member of the resident, registered practical nurses (RPN), personal support workers (PSW), the behavioural support lead, the resident assessment instrument/minimum data set coordinator, the Director of Care, the Administrator, the resident's physician and physiotherapists (both home staff and private). During this inspection the resident was observed, the resident's written plan of care was reviewed and an audio file of a meeting held at the home was reviewed.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident and in the development and implementation of the plan of care so the assessments and different aspects of care were integrated and were consistent with and complement each other. [6(4) (a) (b)]
Staff involved in the provision of physiotherapy and staff involved in the provision of nursing care for resident #001 did not collaborate in the assessment and in the development and implementation of the plan of care with respect to resident #001's ambulation, transfer ability and method of transferring.
a) Physiotherapy staff #004 confirmed that they did not collaborate with physiotherapist #007 in the assessment of resident #001, the progress the resident had made related to transfers and ambulation or in the development of the plan of care related to therapy services provided to the resident.
-The summary of the most recent physiotherapy assessment of resident #001 completed on December 21, 2015 by physiotherapist staff #004 indicated that the resident had maintained ability to weight bear, maintained ability to ambulate with assistance in the preceding quarter, participated in a two person pivot transfer training program, required moderate assistance with transfers and the resident's transfer status was identified as two person pivot transfer. Physiotherapist staff #004 confirmed that resident #001 was provided with therapy services three days a

week, had not been reassessed since December 21, 2015 and the goals of care to increase walking from 30 meters to 60 meters and would be able to do a two person pivot transfer in six weeks had remained the same since June 6, 2015. Physiotherapist #007 confirmed that they provided therapy services twice a week and assessed resident #001's abilities and progress at the time of this inspection as being ambulatory using a walking aid with contact supervision of two people and consistently completed three to four corridors during each therapy session, was ambulatory using a less supportive walking aid with minimum to moderate assistance of two people and consistently completed one half to one corridor during each therapy session, transferred to and from bed with contact supervision of two people, required some verbal cueing but had become very independent, had made significant improvements with transfers and was able to stand independently at the side of the bed using the bed rail for support. Physiotherapist staff #004 confirmed that they had not collaborated with physiotherapist #007 in the assessment of the resident, the goals of care for the resident differed and walking with the less supportive walking aid was not part of physiotherapist staff #004's plan of care for resident #001. Physiotherapist # 007 confirmed that there had not been collaboration with physiotherapist staff #004 in the assessment of resident #001, they were aware that the treatment plan for the resident differed from physiotherapist staff #004's treatment plan and they were also aware that the transfer methods being used by nursing staff differed from the method the physiotherapists were using.

b) Physiotherapist staff #004 and registered nursing staff #005 and #009 confirmed they did not collaborate in the assessment of the resident, the progress the resident had made related to transfers and ambulation or in the development of the plan of care related to transfer method.
-Physiotherapist staff #004 confirmed that following the most recent therapy assessment completed on December 21, 2015 the results of the assessment were documented in resident #001's computerized record under the assessment tab as well as in a progress note and discussions had not been held with nursing staff about the resident's progress in the therapy program. Physiotherapist staff #004 also confirmed that there had not been collaboration with nursing staff related to the resident's ability to transfer using a two person pivot transfer method up to and including the time of this inspection and indicated that they would give input to nursing when asked. Registered staff #005 and #009 confirmed that they were aware that resident #001 was currently able to weight bear, able to stand, able to walk and physiotherapist #004 and #007 had been transferring the resident using a two person pivot transfer method. Registered staff #005 and #009 also confirmed

that the plan of care for resident #001 directed nursing staff to use a mechanical lift to transfer the resident, this transfer method had been use since at least October 27, 2015 and that nursing staff were to provide reassurance during transfers because resident #001 was very frightened during transfers. Registered staff #005 and #009 confirmed that staff providing nursing care to resident #001 had not approached physiotherapist staff #004 regarding the possibility of changing the resident's transfer method and were waiting for physiotherapy staff #004 to let them know when the resident was ready to change transfer methods. [s. 6. (4)]

2. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care, in relation to the following:[6 (5)]
The licensee did not ensure that resident #001's substitute decision maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.
Resident #001's SDM actively provided care to the resident, including feeding the resident meals, assisting the resident to consume snacks and beverages, ensured the resident was assisted to attend recreation and social activities, provided support and encouragement during physiotherapy sessions and came into the home to provide assistance whenever nursing staff called and indicated they were unable to provide care for the resident.
a) Staff did not ensure that resident #001's SDM was given the opportunity to participate fully in the development of the resident #001's plan of care related to methods and techniques for transferring the resident between the bed and chair when they did not consider advise, concerns, comments and observations made by the SDM that the current method of transferring the resident was not consistent with the resident's demonstrated functional abilities and was not effective in meeting the resident's needs.
-Resident #001's SDM requested that nursing staff reassess the resident for the use of a two person pivot transfer technique. The SDM confirmed that this request was in part the result of their observations that the resident was fearful when being transferred by nursing staff who used a total mechanical lift device, the resident was able to consistently transfer using a two person pivot transfer technique when physiotherapists were interacting with the resident as well as when the resident's family were providing care, they wanted the resident to be given the opportunity maintain and improve their ability to weight bear, stand, walk, and be as independent as possible. The SDM also felt that the fear the resident experienced

during transfers when the total mechanical lift device was used by nursing staff may have been a factor that triggered the resident's responsive behaviours when care was provided. Nursing staff did not consider the SDM's request to reassess the transfer technique being used with resident #001 and at the time of this inspection registered nursing staff #005 and #009 confirmed that they had not considered reassessing the resident related to transfer techniques, continued to use the total mechanical lift for all transfers, they were aware of the resident's functional abilities, the resident continued to be fearful when nursing staff used the total mechanical lift device and the resident continued to demonstrate responsive behaviours related to care.

b) Staff did not ensure that resident #001's SDM was given the opportunity to participate fully in the development of the resident #001's plan of care related to possible strategies for the management of responsive behaviours being demonstrated by the resident when they did not consider the SDM's request to implement an evening toileting schedule in order to possibly decrease responsive behaviours being demonstrated by the resident when care was provided.
-The SDM confirmed that information had been provided to nursing staff related to the resident's historical elimination patterns that included large bowel movements usually during the evening. Resident #001 wore incontinent products and the SDM noted that the resident demonstrated more responsive behaviours when nursing staff provided care in the evening particularly when the resident had a bowel movement. The SDM confirmed that they felt this was in part because under this circumstance the resident required more extensive care that took longer to provide. The SDM confirmed that in making this suggestion they hoped this care intervention would somewhat normalize the process of bowel elimination and care for the resident, would reduce the stress the resident experienced when care was provided and as a result possibly reduce the responsive behaviours the resident demonstrated when nursing staff provided this care. The clinical record confirmed the SDM's request that this care intervention be trialled was not considered when at the time of this inspection the plan of care directed staff not to toilet the resident and this care direction had been in place since April 17, 2015. Registered nursing staff #009 and #006 confirmed; resident #001 would become more agitated when care was provided after having a bowel movement; resident #001's SDM knew the resident well and had the best intentions and approach for resident #001; they were aware of the resident's abilities related to weight bearing and walking; they were aware continence monitoring data collected during the evening of June 14,2015 through to the evening of June 18, 2015 indicated that on each of these days the resident #001 was identified as having had a bowel movement at

1931hrs, 1923hrs, 2006hrs and 1947hrs and data collected over a four day period between October 1, 2015 to October 4, 2015 indicated that resident #001 had bowel movements in the evening on two of these four days. Registered staff #006 and #009 also confirmed that the suggested care intervention made by resident #001's SDM had not been implemented and resident #001 continued to demonstrate responsive behaviours when personal care was provided, particularly in the evening.

c) Staff did not ensure that resident #001's SDM was given the opportunity to participate fully in the development and implementation of resident #001's plan of care related to the use of medications and proposed use of medications as a care intervention to manage responsive behaviours being demonstrated by the resident. Registered staff did not provide information related to the effectiveness of a medication that was being administered, did not take action to stop the use of the medication when the SDM directed that they had withdrawn consent for the administration of the medication and did not provide sufficient information to allow the SDM to provide informed consent to a proposed treatment to be used in the management of responsive behaviours.
Resident 001's SDM had made a decision to withdraw consent for the as necessary use of an identified medication that the resident's physician had ordered on December 10, 2015 because they felt staff were not using the drug appropriately, they could see no benefit from the use of the drug and they felt the resident appeared more drowsy when the medication was administered. Staff and clinical documentation confirmed that the SDM communicated this decision to the Director of Care (DOC) and registered staff #009 on January 28, 2016. The DOC confirmed that on the same day they spoke with the resident's physician and communicated the SDM's decision to withdraw their consent for the use of the identified medication. During an interview with resident #001's physician on February 25, 2016 it was confirmed that the physician was aware that the SDM had withdrawn consent for the administration of the identified medication. Resident #001's physician confirmed that as a result of the SDM's decision they provided verbal direction to registered staff working at the time to give an alternate medication instead of the identified medication and they did not write an order to either discontinue the use of the identified medication or administer the alternate medication. Resident #001's SDM confirmed that registered nursing staff #006 approached the resident during the evening of February 1, 2016 to administer a medication to the resident, when the SDM questioned the medication the staff indicated it was the identified medication and the SDM indicated that the medication had been discontinued. Registered staff #006 confirmed that at this

time they were unable to locate an order for the discontinuation of the medication, chose not to hold the as necessary medication until the information provided by the SDM had been clarified and administered the medication at 1938hrs on February 1, 2016.

d) Staff and others involved in the care of resident #001 did not ensure the resident's SDM was given the opportunity to participate fully in the development of the resident #001's plan of care related to a proposed pharmaceutical treatment for the management of responsive behaviours being demonstrated by resident #001. During a meeting held in the home on February 4, 2016 resident #001's physician proposed a new medication be added to the resident's plan of care. The SDM informed the physician they did not have enough information to provide an informed consent for the use of this proposed treatment. An audio recording of this meeting indicated that the Administrator, Director of Care, registered staff #009, the resident's physician, resident #001's SDM and a private care provider were in attendance. During the conversation the SDM was not provided with information about the proposed drug treatment. Resident #001's SDM confirmed that they were unable to make an informed decision about this change to the resident's plan of care and as a result was unable to provide consent for the use of the proposed drug treatment.

e) Staff did not ensure that resident #001's SDM was given the opportunity to participate fully in the development of the resident's plan of care related to additional care interventions suggested by the SDM to ensure the resident was able to eat safely and consume as much of the food provided as possible.
- Resident #001's plan of care indicated the resident had difficulty eating related to chewing and swallowing difficulties. Following an assessment by a speech language pathologist, resident #001's nutritional plan of care was changed and specific food and fluid types as well as feeding techniques were identified. Resident #001's SDM confirmed that they and or a private registered nurse fed the resident meals and snacks during the day and into the early evening. The SDM confirmed that when the resident was not assisted out of bed and into the wheelchair for their meals the resident did not eat as well and often consumed less food than when the resident was sitting in the wheelchair. Based on this observation and their experience feeding the resident the SDM approached registered nursing staff #005 on March 8, 2016 and requested that staff be directed to assist the resident to sit in their wheelchair for all meals and this intervention be added to the resident's plan of care. The SDM confirmed that registered staff #005 indicated that this intervention would not be added to the resident's plan of care because they could

not guarantee that resident #001 would be up and sitting in their chair for every meal. During an interview with registered staff #005 on March 8, 2016 they confirmed that the SDM had made the request and that this intervention had not been added to resident #001's plan of care. Staff and the clinical record confirmed that no action was taken to consider the SDM's request that the resident be assisted up from bed to sit in their wheelchair for all meals in order to improve nutritional intake.

f) Staff did not ensure that resident #001's SDM was given the opportunity to participate fully in the implementation of the resident's plan of care when staff directed them to leave the room whenever nursing staff provided care to the resident. Staff and the SDM confirmed that the SDM was in the home and provided care to the resident regularly and that the SDM would come into the home to assist with care whenever staff would call and indicated the resident was non-compliant with care. During an interview on February 26, 2016 the Director of Care (DOC) confirmed that staff had been directed that the SDM was not to be allowed in the resident's room when care was provided. The DOC indicated that this direction was to have been implemented on a trial basis because staff felt the SDMs presence may increase the anxiety experienced by the resident, based on nursing staff's assumption that the resident demonstrated responsive behaviours during personal care due to privacy issues. The DOC confirmed that the effectiveness of this intervention had not been evaluated, the resident continued to demonstrate responsive behaviours and this care intervention had not been changed. The SDM indicated that by not being allowed to be in the room when care was provided they were unable to monitor staff's provision of care, the resident's response to care or to provide support and encouragement to the resident as well as possible distraction in order for staff to be able to complete the care for the resident without the resident demonstrating responsive behaviours. [s. 6. (5)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment and in the development and implementation of the plan of care so the assessments and the different aspects of care are integrated and consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 failed to ensure that, for each resident demonstrating responsive behaviour that actions were taken to respond to the needs of the resident, including assessment, reassessment and interventions and that the resident's responses to interventions were documented. [53(4) (c)]
1. Actions were not taken to assess Resident #001's behavioural responses or the effectiveness of interventions to reduce responsive behaviours that had been demonstrated.
a) Registered nursing staff #005, #006 and #009 and clinical documentation

confirmed that responsive behaviours that were demonstrated by resident #001 were not assessed. Registered nursing staff #005, #006 and #009 confirmed that behavioural data collected was not consistent with the detailed data collection required in the home's policy tilted "Responsive Behaviours" and as a result was not useful to complete a comprehensive assessment of the behaviours, determine possible triggers for the behaviour or implement strategies to manage the triggers for the responsive behaviours being demonstrated by resident #001. When registered staff #005, #006 and #007 were asked what they had identified as possible triggers for the behaviours being demonstrated, they indicated that the behaviours were demonstrated during the provision of care and concluded that the resident must be responding like they were because they were a private person. When it was identified that personal support workers (PSW) had documented a concentrated pattern of behaviours being demonstrated during the evening shift registered nursing staff #005, #006 and #009 confirmed that they had not assessed this pattern and were unable to explain why staff providing the same care during the day and night shifts did not document the same level of responsive behaviours. When it was identified that on several occasions PSW staff who had worked the evening shift had documented that the resident did not demonstrate behaviours, the above noted staff confirmed that this pattern had not been assessed to determine why the resident did not demonstrate responsive behaviours when these staff provided care. Registered nursing staff #006 confirmed during an interview that they felt this pattern of behaviours was in part due to the approach different PSWs used when providing care to the resident, they had reported their concerns to the Director of Care (DOC) and no action had been taken to determine if the demonstration of responsive behaviours could be the result of different approaches to care being used by staff.

b) Registered nursing staff #005, #006 and #007 confirmed that actions were not taken to assess the use or effectiveness of an as necessary medication ordered to be used to assist in the management of responsive behaviours demonstrated by resident #001. Clinical documentation confirmed that an assessment of the usage pattern or the effectiveness of the medication had not been completed. On February 4, 2015 staff in the home called a meeting with resident #001's substitute decision maker (SDM) and proposed adding a new medication to the resident's plan of care despite not having assessed the usage pattern or effectiveness of the previous medication. During this meeting the SDM was told that the responsive behaviours being demonstrated by the resident were no longer manageable.

2. Actions were not taken to reassess the effectiveness of interventions for care or

to revise interventions related to the management of responsive behaviours being demonstrated by resident #001 when the goals of care identified in the resident' plan of care had not been met. The goal of care related to the behavioural focus of care for resident #001 indicated that the resistive behaviour would be reduced through the next review. This goal was initiated on May 19, 2015 and remained a current goal of care at the time of this inspection. Clinical documentation, registered staff #005, #006, #007, the Director of Care, the resident's physician and the Administrator confirmed at the time of this inspection the resident's responsive behaviours had not been reduced and the home felt they could no longer provide care to the resident due to the responsive behaviours being demonstrated. A review of the interventions identified in the plan of care indicated no new non pharmacological care interventions had been added to resident #001's plan of care since November 4, 2015 despite staff indicating that the resident's responsive behaviours were no longer manageable. [s. 53. (4) (c)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: 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 failed to ensure that where the Act or this Regulation required the licensee to have , institute or otherwise put in place any policy or procedure that the policy or procedure was complied with, in relation to the following: [8(1)(b)]
The licensee failed to ensure that staff complied with the directions contained in the home's policy titled "Responsive Behaviours" located in the Resident Care Manual, identified as #09-05-01 and dated September 2010.
1) This policy directed that "all staff are responsible for completing accurate documentation in the resident's health record or on the Responsive Behaviour Record when behaviours are observed, the documentation should clearly describe any identified triggers for the behaviour, how behaviour was displayed, what was observed in the immediate surroundings, what interventions were tried, what interventions were successful, what additional actions were taken by staff or others and any negative experience or outcome for the resident or another person/resident".
a) The documentation entered into resident #001's clinical record by personal support workers (PSW) when resident #001 was observed to demonstrate responsive behaviours did not include specific details of each behavioural episode as required in the home's policy.
-At the time of this inspection PSW staff used the Dementia Observational Scale (DOS) tool to document responsive behaviours. When resident #001 was observed to demonstrate responsive behaviours PSW staff documented this behaviour by entering a number on a paper copy of the DOS form to indicate a positive response to non-specific, broad categories of behaviours. A review of this documentation indicated that PSW staff had identified four broad categories of responsive behaviours and then placed the number selected in a place that corresponded to the time, in half hour increments when resident #001 was observed to have

demonstrated the responsive behaviour in the identified catagory. Documentation by PSW staff of behaviours demonstrated by resident #001using the DOS tool did not comply with the requirements for documentation as directed in the home's policy.
-At the time of this inspection PSW staff also used a component of the computerized clinical record known as Point of Care (POC) to document responsive behaviours. When resident #001 was observed to have demonstrated responsive behaviours PSW staff entered a check mark into the POC component to indicate a positive response to questions about behaviour. These questions identify broad categories of behaviours available for staff to select and included:
1. Persistent anger with self or others exhibited?
2. Resists Care (resisted taking medications/injections, ADL assistance, or eating) exhibited?
3. Verbally Abusive Behavioural Symptoms (others were threatened, screamed at, cursed at) exhibited?
4. Physically Abusive Behavioural Symptoms (intent to hit others, others were hit, shoved, scratched, sexually abused) exhibited?
Documentation by PSW staff of behaviours demonstrated by resident #001using the POC component of the computerized record did not comply with the requirements for documentation as directed in the home's policy.
b) Registered nursing staff used the computerized record and specifically the progress note function to document responsive behaviours demonstrated by resident #001. A random review of the progress notes for the first five days of February 2016 indicated the following documentation:
-February 1, 2016 at 2132hr-"Behaviour Displayed: Resident very resistive to care and very physically abusive to staff this shift."
-February 2, 2016 at 2112hrs-"Behaviour Displayed: Resident resistive to care and physically aggressive while care was given."
- February 3, 2016 at 1650hrs –"Late Entry-Behaviour Displayed: Personal Support Worker (PSW) reported that resident was resistive to care and was attempting to hit staff during care."
Documentation by registered staff of the responsive behaviours demonstrated by resident #001using the progress note function of the computerized record did not comply with the requirements for documentation as directed in the home's policy.
Registered staff #005, #006 and #007 confirmed during interviews that they were unaware of the direction for documentation of responsive behaviours contained in the home's policy, were unaware of the documentation tool included in the home's policy and also confirmed that the documentation tool included in the home's policy was not used to document the responsive behaviours demonstrated by resident

#001.

2) This policy directed that "registered staff initiating pharmacological interventions related to one or more behaviours is to document in the progress notes the residents response to the medication weekly for the first 6 weeks".
Registered staff #005, #006 and #007 confirmed that this policy was not complied with when they indicated that an identified medication ordered to be administered to resident #001 on an as necessary basis on December 10, 2015 had not been evaluated to identify the resident's response to the medication up to and including the time of this inspection. The medication administration records for December 2015, January 2016 and February 2016 indicated that this medication was administered to the resident during these months
Registered nursing staff #005, #006 and #007 confirmed during interviews that they were unaware of this direction contained in the home's policy.. [s. 8. (1) (b)]

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 and ensure that where the Act or this Regulation required the licensee to have, institute or otherwise put in place any policy or procedure that the policy or procedure is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents in 2015 received annual training in accordance O. Reg. 221(2) 1, as a condition of continuing to have contact with residents in the area of behaviour management. [76(7) 3]
Documents provided by the home at the time of this inspection indicated that staff who provided direct care to residents in 2015 continued to provide care to residents when they had not received training in the area of behaviour management. The Director of Care provided documentation to demonstrate training that had occurred in 2015 related to behaviour management and confirmed that there were 114 staff in the home who provided direct care to residents in 2015. The documents provided at the time of this inspection confirmed that 73 of 114 staff who were identified as providing direct care to residents in 2015 had not received training in the area of behaviour management. [s. 76. (7) 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 and ensuring that all staff who provide direct care to residents receive annual retraining in the are of behaviour management as a condition of continuing to have contact with residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 83. Coercion prohibited

Specifically failed to comply with the following:

s. 83. (1) Every licensee of a long-term care home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,
(a) a document has not been signed; 2007, c. 8, s. 83. (1).
(b) an agreement has been voided; or 2007, c. 8, s. 83. (1).
(c) a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked. 2007, c. 8, s. 83. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no person was told or led to believe that a resident would be discharged from the home because a consent or directive with respect to treatment or care had not been given, not given, withdrawn or revoked. [83(1)(c)]
Resident #001's substitute decision maker (SDM) confirmed that comments made by home staff at a meeting called by the home on February 4, 2016 caused them to believe that the resident would have to be relocated (discharged) from the home within 24 hours if the SDM did not consented to a specific pharmaceutical care recommendations and all recommendations made by specialists and that the time frame for this action was identified as 24 hours. The SDM confirmed that following this meeting they sought advice in order to prevent the resident from being discharged from the home.
- Resident #001's physician, who was in attendance at the meeting held on

February 4, 2016 confirmed that as a result of what staff at the meeting communicated to resident #001's SDM, they could see that it was possible that the SDM could have taken comments made as a threat that the resident would be discharged if they did not consent to recommendations made for the care of the resident.
- The Director of Care (DOC), who was in attendance at the meeting held on February 4, 2016, confirmed that they took notes during the meeting and then transcribed those notes into resident #001's clinical record. The DOC confirmed that the account of discussions at the meeting transcribed into the clinical record was an accurate account of the discussions at the meeting. The DOC also confirmed that comments made at the meeting and recorded in the progress note could have been interpreted as a threat to discharge resident #001.
- The Administrator, who was in attendance at the meeting held on February 4, 2016, confirmed, after reading the DOC's account of the meeting transcribed into resident #001's clinical record on February 4, 2016, that the note accurately reflected the comments made at the meeting.
- Comments made at the meeting and transcribed into resident #001's clinical record included:
"The facility and the care team are at the point of not being able to offer the best care for the resident. The facility is not able to follow recommendations from specialists due to the SDM not consenting to recommendations. This barrier in the resident's care has to be removed as we are in a lose, lose, lose situation, from the perspective of the resident/SDM/staff. The SDM needs to make a decision to remove the barrier to care, or to relocate the resident as we can no longer manage the resident's care here. The SDM was asked to think this through and provide the home with an answer in 24 hours." [s. 83. (1) (c)]

Issued on this 9 day of August 2016 (A1)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : PHYLLIS HILTZ-BONTJE (129) - (A1)

Inspection No. / No de l'inspection : 2016_205129_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 003711-16 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Aug 09, 2016;(A1)

Licensee / Titulaire de permis :
EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD :
EXTENDICARE HALTON HILLS
9 Lindsay Court, Georgetown, ON, L7G-6G9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Sean Weylie

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Order / Ordre :

(A1)

The licensee shall prepare, submit and implement a plan for corrective action to ensure that the resident's substitute decision maker and any other person designated by the resident or substitute decision maker are given an opportunity to participate fully in the development and implementation of the plan of care. The plan shall include, but is not limited to the following:

1. The licensee shall develop and implement a training program for regulated staff that includes the identification of the role, responsibility and authority of the resident's substitute decision maker (SDM) or any other person designated by the resident in accordance with the Substitute Decisions Act, 1992, S.O. 1992, c. 30 and also the requirements for obtaining consent for proposed care and treatment, in accordance with the Health Care Consent Act, 1996 and established Professional Colleges practice standards.
2. The licensee shall develop and implement a training program for regulated staff in the development and maintenance of a therapeutic relationship with SDMs and any other person designated by the resident, in accordance with established Professional Colleges practice standards. This training program is to include a discussion of opportunities for resident's SDMs and any other person designated by the resident to participate fully in the development and implementation of the resident's plan of care.
3. The licensee shall develop and implement a system for the regular monitoring of staff's performance in the development and maintenance of the therapeutic relationship and obtaining consent for proposed care and treatment.

The plan is to be submitted on or before August 26. 2016 to the attention of Phyllis Hiltz-Bontje by e-mail at HamiltonSAO.MOH@ontario.ca

Grounds / Motifs :

(A1)

1. Previously identified as non-compliant on February 26, 2014 as a written notification (WN)
2. Multiple non-compliance previously issued in relation to the plan of care as follows:

-July 24, 2014 – s. 6(1)(c), s. 6 (2), s. 6(7) issued as voluntary plans of correction (VPC)

-December 14, 2014 – s. 6(7) issued as a VPC

-April 17, 2015 – s. 6(1)(c) issued as a WN

-February 25, 2015 – s. 6(10) served as a CO

-July 17, 2015 – s. 6(1)(a) and s. 6(10)(b) issued as a VPC

3. The licensee did not ensure that resident #001's substitute decision maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #001's SDM actively provided care to the resident, including feeding the resident meals, assisting the resident to consume snacks and beverages, ensured the resident was assisted to attend recreation and social activities, provided support and encouragement during physiotherapy sessions and came into the home to provide assistance whenever nursing staff called and indicated they were unable to provide care for the resident. The SDM hired a registered physiotherapist to provide additional therapy for the resident two days a week and hired a registered nurse to provide care to the resident and respite for themselves. The SDM or private care provider were in the home every day interacting with the resident, providing care or just sitting with the resident while they slept from early morning into the evening.

a) Staff did not ensure that resident #001's SDM was given the opportunity to participate fully in the development of the resident #001's plan of care related to methods and techniques for transferring the resident between the bed and chair when they did not consider advise, concerns, comments and observations made by the SDM that the current method of transferring the resident was not consistent with the resident's demonstrated functional abilities and was not effective in meeting the resident's needs. Nursing staff completed a transfer assessment on October 27, 2015 when it was determined the resident was unsafe for the use of a sit-to-stand lift for transfers between the bed and chair and changed the resident's plan of care to indicate that staff were to use a total mechanical lift for all transfers.

-Resident #001's SDM requested that nursing staff reassess the resident for the use of a two person pivot transfer technique. The SDM confirmed that this request was in part the result of their observations that the resident was fearful when being transferred by nursing staff who used the total mechanical lift device, the resident was able to consistently transfer using a two person pivot transfer technique when physiotherapy staff where interacting with the resident as well as when the resident's family were providing care, they wanted the resident to be given the opportunity maintain and improve their ability to weight bear, stand, walk, and be as independent as possible. The SDM also felt that the fear the resident experienced during transfers when the total mechanical lift device was used by nursing staff may have been a factor that triggered the resident's responsive behaviours when care was provided. Nursing staff did not consider the SDM's request to reassess the transfer technique being used with resident #001.

-At the time of this inspection registered nursing staff #005 and #009 confirmed they

had not initiated a reassessment of the transfer method nursing staff were using for the resident despite requests from the resident's SDM and continued to use a total mechanical lift for all transfers. The above noted staff also confirmed their awareness of the resident's functional ability to stand, the resident demonstrated fear and continued to demonstrate responsive behaviours during the use of the mechanical lift, the resident had been receiving physiotherapy five days a week and they were aware that physiotherapists and the resident's family had been transferring the resident using a two person pivot transfer method for approximately three and a half months. Both of the above mentioned staff indicated they had not initiated a reassessment of the transfer method because they were "waiting for the physiotherapist to provide the OK to go ahead with a two person pivot transfer method".

b) Staff did not ensure that resident #001's SDM was given the opportunity to participate fully in the development of the resident #001's plan of care related to possible strategies for the management of responsive behaviours being demonstrated by the resident when they did not consider the SDM's request to implement an evening toileting schedule in order to possibly decrease responsive behaviours being demonstrated by the resident when care was provided.

-The SDM confirmed that information had been provided to nursing staff related to the resident's historical elimination patterns that included large bowel movements usually during the evening. Resident #001 wore incontinent products and the SDM noted that the resident demonstrated more responsive behaviours when nursing staff provided care in the evening particularly when the resident had a bowel movement. The SDM confirmed that they felt this was in part because under this circumstance the resident required more extensive care that took longer to provide. The SDM confirmed that in making this suggestion they hoped this care intervention would somewhat normalize the process of bowel elimination and care for the resident, would reduce the stress the resident experienced when care was provided and as a result possibly reduce the responsive behaviours the resident demonstrated when nursing staff provided this care. The clinical record confirmed the SDM's request that this care intervention be trialled was not considered when at the time of this inspection the plan of care directed staff not to toilet the resident and this care direction had been in place since April 17, 2015. Registered nursing staff #009 and #006 confirmed: resident #001 would become more agitated when care was provided after having a bowel movement; resident #001's SDM knew the resident well and had the best intentions and approach for resident #001; they were aware of the resident's abilities related to weight bearing and walking; they were aware continence monitoring data collected during the evening of June 14,2015 through to

the evening of June 18, 2015 indicated that on each of these days the resident #001 was identified as having had a bowel movement at 1931hrs, 1923hrs, 2006hrs and 1947hrs and data collected over a four day period between October 1, 2015 to October 4, 2015 indicated that resident #001 had bowel movements in the evening on two of these four days. Registered staff #006 and #009 also confirmed that the suggested care intervention made by resident #001's SDM had not been implemented and resident #001 continued to demonstrate responsive behaviours when personal care was provided, particularly in the evening.

4. Staff did not ensure that resident #001's SDM was given the opportunity to participate fully in the development and implementation of resident #001's plan of care related to the use of medications and proposed use of medications as a care intervention to manage responsive behaviours being demonstrated by the resident. Registered staff did not provide information related to the effectiveness of a medication that was being administered, did not take action to stop the use of the medication when the SDM directed that they had withdrawn consent for the administration of the medication and did not provide sufficient information to allow the SDM to provide informed consent to a proposed to be used in the management of responsive behaviours.
a) Resident 001's SDM had made a decision to withdraw consent for the as necessary use of Trazodone that the resident's physician had ordered on December 10, 2015 because they felt staff were not using the drug appropriately, they could see no benefit from the use of the drug and they felt the resident appeared more drowsy when the medication was administered. Staff and clinical documentation confirmed that the SDM communicated this decision to the Director of Care (DOC) and registered staff #009 on January 28, 2016. The DOC confirmed that on the same day they spoke with the resident's physician and communicated the SDM's decision to withdraw their consent for the use of Trazodone. During an interview with resident #001's physician on February 25, 2016 it was confirmed that the physician was aware that the SDM had withdrawn consent for the administration of Trazodone. Resident #001's physician confirmed that as a result of the SDM's decision they provided verbal direction to registered staff working at the time to give Ativan instead of the Trazodone and they did not write an order to either discontinue the use of Trazodone or administer to Ativan in place of the Trazodone. Resident #001's SDM confirmed that registered nursing staff #006 approached the resident during the evening of February 1, 2016 to administer a medication to the resident, when the SDM questioned the medication the staff indicated it was Trazodone and the SDM indicated that the medication had been discontinued. Registered staff #006

confirmed that at this time they were unable to locate an order for the discontinuation of the medication, chose not to hold the as necessary medication until the information provided by the SDM had been clarified and administered the medication at 1938hrs on February 1, 2016.

b) Staff and others involved in the care of resident #001 did not ensure the resident's SDM was given the opportunity to participate fully in the development of the resident #001's plan of care related to a proposed pharmaceutical treatment for the management of responsive behaviours being demonstrated by resident #001. During a meeting held in the home on February 4, 2016 resident #001's physician proposed a new medication be added to the resident's plan of care. The SDM informed the physician they did not have enough information to provide an informed consent for the use of this proposed treatment. An audio recording of this meeting indicated that the Administrator, Director of Care, registered staff #009, the resident's physician, resident #001's SDM and a private care provider were in attendance. During the conversation the SDM was not provided with information about the proposed drug treatment. Resident #001's SDM confirmed that they were unable to make an informed decision about this change to the resident's plan of care and as a result was unable to provide consent for the use of the proposed drug treatment.

5. Staff did not ensure that resident #001's SDM was given the opportunity to participate fully in the development of the resident's plan of care related to additional care interventions suggested by the SDM to ensure the resident was able to eat safely and consume as much of the food provided as possible.
- Resident #001's plan of care indicated the resident had difficulty eating related to chewing and swallowing difficulties. Following an assessment by a speech language pathologist, resident #001's nutritional plan of care was changed and specific food and fluid types as well as feeding techniques were identified. Resident #001's SDM confirmed that they and or the private registered nurse fed the resident meals and snacks during the day and into the early evening. The SDM confirmed that when the resident was not assisted out of bed and into the wheelchair for their meals the resident did not eat as well and often consumed less food than when the resident was sitting in the wheelchair. Based on this observation and their experience feeding the resident the SDM approached registered nursing staff #005 on March 8, 2016 and requested that staff be directed to assist the resident to sit in their wheelchair for all meals and this intervention be added to the resident's plan of care. The SDM confirmed that registered staff #005 indicated that this intervention would not be added to the resident's plan of care because they could not guarantee that resident

#001 would be up and sitting in their chair for every meal. During an interview with registered staff #005 on March 8, 2016 they confirmed that the SDM had made the request and that this intervention had not been added to resident #001's plan of care. Staff and the clinical record confirmed that no action was taken to consider the SDM's request that the resident be assisted up from bed to sit in their wheelchair for all meals in order to improve nutritional intake.

6. Staff did not ensure that resident #001's SDM was given the opportunity to participate fully in the implementation of the resident's plan of care when staff directed them to leave the room whenever nursing staff provided care to the resident. During an interview with the resident's SDM they expressed concerns about not being allowed in the room when care was provided because they were unable to monitor staff's provision of care, the resident's response to care or to provide support and encouragement to the resident as well as possible distraction in order for staff to be able to complete the care for the resident without the resident becoming upset and demonstrating responsive behaviours. The SDM confirmed that up to and including the time of this inspection staff providing care to the resident would direct the SDM to leave the room.
-The first care intervention, in the resident's current plan of care for the management of behaviours initiated four months prior to this inspection, directed staff to "call the POA any time if staff are unable to provide care to the resident due to their behaviour. POA will come in and assist with care".
- Staff and the SDM confirmed that the SDM was in the home and provided care to the resident on a daily basis and that the SDM would come into the home to assist with care whenever staff would call and indicated the resident was non-compliant with care. During an interview on February 26, 2016 the Director of Care (DOC) confirmed that staff had been directed that the SDM was not to be allowed in the resident's room when care was provided. The DOC indicated that this direction was to be implemented on a trial basis because staff felt the SDMs presence may increase the anxiety experienced by the resident, based on nursing staff's assumption that the resident demonstrated responsive behaviours during personal care possibly due to privacy issues. The DOC confirmed that the effectiveness of this direction had not been evaluated and the resident continued to demonstrate responsive behaviours while care was being provided. The plan of care related to the management of behaviours did not contain directions to staff to instruct the SDM to leave the room when care was being provided and the SDM was prevented from participating fully in the implementation of the resident's plan of care.

(129)

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

Sep 23, 2016(A1)

Order # /
Ordre no : 002

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

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 :

(A1)
The licensee shall prepare submit and implement a plan to ensure that actions are taken for each resident who demonstrates responsive behaviours. The plan is to include, but is not limited to the following:
1. The licensee shall implement a strategy/tool to ensure that when staff document responsive behaviours being demonstrated by residents the required information about those behaviours, in accordance with the home's policy "Responsive Behaviours" located in the Resident Care Manual, identified as #09-05-01 and dated September 2010 will be documented.
2. The licensee shall develop and implement a training program in the area of behaviour management, for all staff who provide direct care to residents. This training shall be based on established best practice guidelines and directions contained in the homes policy. This training shall include case studies from specific situations that have occurred in the home as well as opportunities for staff to discuss the case studies presented and provide suggestions for ways to improve the strategies for responsive behaviour management. This training program shall also include specific training related to the collection of behavioural data based on the strategy/tool implemented and methods used to analyze behavioural data collected in order to assess behaviours for possible triggers and possible care interventions to manage behavioural triggers.
3. The development and implement of a process to ensure an individual resident specific schedule for the reassessment of the effectiveness of interventions to manage responsive behaviours that is based on the frequency with which the behaviour was being demonstrated and the identified potential risk for injury to themselves or others is identified. The reassessment schedule shall be updated based on the needs of the resident and documented in the resident's plan of care.
4. The licensee shall develop and implement an ongoing schedule for monitoring staff's performance in the management of responsive behaviours for all residents demonstrating responsive behaviours in the following areas:
-documentation of behavioural data consistent with the home's policy when a resident demonstrates responsive behaviours.
-The documentation of the assessment of data collected, identification of behavioural triggers and subsequent revisions to the resident's plan of care.
-Appropriate reassessment have been completed, where necessary the plan of care has been revised and the reassessment is clearly documented in the resident's clinical record.

- All staff have received annual retraining in the area of behaviour management in order to continue to have contact with residents.
The plan is to be submitted on or before August 26, 2016 to the attention of Phyllis Hiltz-Bontje by e-mail at HamiltonSAO.MOH@ontario.ca.

Grounds / Motifs :

1. Previously issued non-compliant -53(4)(b) on December 14, 2014 as a voluntary plan for corrective action (VPC) and 53(4) on July 24, 2014 as a compliance order (CO).

2. Actions were not taken to assess Resident #001's behavioural responses or the effectiveness of interventions to reduce responsive behaviours that had been demonstrated.
a) Registered nursing staff #005, #006 and #009 and clinical documentation confirmed that responsive behaviours being demonstrated by resident #001 were not assessed. Registered nursing staff #005, #006 and #009 confirmed that behavioural data collected was not consistent with the detailed data collection required in the home's policy tilted "Responsive Behaviours" and as a result was not useful to complete a comprehensive assessment of the behaviours, determine possible triggers for the behaviour or implement strategies to manage the triggers for the responsive behaviours being demonstrated by resident #001. When registered staff #005, #006 and #007 were asked what they had identified as possible triggers for the behaviours being demonstrated, they indicated that the behaviours were demonstrated during the provision of care and concluded that the resident must be responding like they were because they were a private person. When it was identified that personal support workers (PSW) had documented a concentrated pattern of behaviours being demonstrated during the evening shift registered nursing staff #005, #006 and #009 confirmed that they had not assessed this pattern and were unable to explain why staff providing the same care during the day and night shifts did not document the same level of responsive behaviours. When it was identified that on several occasions PSW staff who had worked the evening shift had documented that the resident did not demonstrate behaviours, the above noted staff confirmed that this pattern had not been assessed to determine why the resident did not demonstrate responsive behaviours when these staff provided care. Registered nursing staff #006 confirmed during an interview that they felt this pattern of behaviours was in part due to the approach different PSWs used when providing care to the resident, they had reported their concerns to the Director of Care (DOC)

and no action had been taken to determine if the demonstration of responsive behaviours could be the result of different approaches to care being used by staff.

b) Registered nursing staff #005, #006 and #007 confirmed that actions were not taken to assess the use or effectiveness of an as necessary medication ordered to be used to assist in the management of responsive behaviours demonstrated by resident #001. Clinical documentation confirmed that an assessment of the usage pattern or the effectiveness of the medication had not been completed. On February 4, 2015 staff in the home called a meeting with resident #001's substitute decision maker (SDM) and proposed adding a new medication to the resident's plan of care despite not having assessed the usage pattern or effectiveness of the previous medication. During this meeting the SDM was told that the responsive behaviours being demonstrated by the resident were no longer manageable.

3. Actions were not taken to reassess the effectiveness of interventions for care or to revise interventions related to the management of responsive behaviours being demonstrated by resident #001 when the goals of care identified in the resident's plan of care had not been met. The goal of care related to the behavioural focus of care for resident #001 indicated that the resistive behaviour would be reduced through the next review. This goal was initiated on May 19, 2015 and remained a current goal of care at the time of this inspection. Clinical documentation, registered staff #005, #006, #007, the Director of Care, the resident's physician and the Administrator confirmed at the time of this inspection the resident's responsive behaviours had not been reduced and the home felt they could no longer provide care to the resident due to the responsive behaviours being demonstrated. A review of the interventions identified in the plan of care indicated no new non pharmacological care interventions had been added to resident #001's plan of care since November 4, 2015 despite staff indicating that the resident's responsive behaviours were no longer manageable.

(129)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Sep 30, 2016(A1)

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
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 9 day of August 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

Service Area Office /
Bureau régional de services : Hamilton