Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 13, 2015	2015_395613_0015	021577-15	Resident Quality Inspection

Licensee/Titulaire de permis

BLIND RIVER DISTRICT HEALTH CENTRE
525 Causley Street P.O. Box 970 BLIND RIVER ON P0R 1B0

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

BLIND RIVER DISTRICT HEALTH CENTRE - LTC UNIT
525 CAUSLEY STREET P. O. BOX 970 BLIND RIVER ON P0R 1B0

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

LISA MOORE (613), JENNIFER LAURICELLA (542)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 21 - 25 and September 28 - October 2, 2015

Additional log completed during this inspection: 006226-15. This inspection addresses both the Blind River District Health Centre, Long Term Care Unit #2865 and the ELDCAP Unit #2795.

During the course of the inspection, the inspector(s) spoke with the Long Term Care Nurse (LTC) Manager, Registered Dietician, Behavioural Supports Ontario (BSO) Registered Practical Nurse, Physiotherapy Assistant, Maintenance Helper, Personal Support Worker/Unit Aid Assistant, Housekeeping staff, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Family Members.

During the course of the inspection, the Inspectors conducted a walk through of the resident home area and various common areas, made direct observations of the delivery of care and services provided to the residents, observed staff to resident interaction, reviewed resident health care records and various policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

11 WN(s)
5 VPC(s)
0 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. (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. (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 that the plan of care set out clear directions to staff and others who provide direct care to residents #016 and #018 in regards to the use of their restraints.

Inspector #613 completed a health care record review for resident #016. The most current care plan accessible to the direct care staff indicated that resident #016 had a restraint, bed rails when in bed.

On September 28, 2015, Inspector #613 reviewed forms titled 'Restraint Record' for resident #016 from March 2015 to September 2015 which identified that staff had only documented on the September Restraint Record form up to September 22, 2015. Inspector reviewed Doctor's orders and could not find an order to identify that the restraint had been discontinued. Inspector checked the progress notes on point click care and was unable to locate documentation explaining why the restraint record use was not completed post September 22, 2015.

On September 29, 2015, Inspector #613 met with S#107 who informed the Inspector that

resident #016's bed rails were no longer considered a restraint but rather a PASD. S#107 informed Inspector that the bed rails were to support resident #016's mattress and keep it in place. Inspector #613 asked S#107 if an order to discontinue the restraint had been received and if the current care plan accessible to staff had been updated to reflect bed rails as a PASD. S#107 verified that no order was received to discontinue the restraint and that the care plan had not been updated to provide clear direction to staff.

On September 30, 2015, Inspector #613 met with the LTC Nurse Manager who confirmed that resident had bed rails while in bed. The LTC Nurse Manger identified that the bed rails while in bed were no longer considered a restraint since September 23, 2015 and were now considered a PASD. The LTC Nurse Manager confirmed that the restraint order had not been discontinued and the care plan had not been updated. The LTC Nurse Manger informed the Inspector that they were in the process of performing a reassessment and were directing staff to update the care plans and get doctor to discontinue the restraint. [s. 6. (1) (c)]

2. Inspector #613 completed a health care record review for resident #018. The most current care plan accessible to the direct care staff indicated that resident #018 had a restraint, seat belt while in wheelchair and bed rails in the up position while in bed.

On September 28, 2015, Inspector #613 reviewed forms titled 'Restraint Record' for resident #018 from July 2015 to September 2015 which identified that staff had only documented on the September Restraint Record form up to September 22, 2015. Inspector reviewed the Doctor's orders and could not find an order to identify that the restraint had been discontinued. Inspector checked the progress notes on point click care which identified that the LTC Nurse Manager had contacted resident #018's Power of Attorney for Care (POA) and had documented that the positioning belt on resident #018's wheelchair would no longer be considered a restraint but rather a PASD to assist with positioning. The documentation also identified that staff had been implementing other safety interventions while the resident was in bed. It was documented that these interventions had worked well and resident #018 had not been attempting to get out of bed. Therefore all restraints were discontinued and resident #018's POA had been in agreement.

On September 29, 2015, Inspector #613 met with S#107 who stated resident #018's seat belt and bed rails were no longer considered a restraint. The straps on the seat belt were for positioning resident while in wheelchair and bed rails while in bed allows resident to reposition self and both were now considered a PASD. Inspector informed

S#107 that the care plan accessible to staff still identifies seat belt and bed rails as restraints with goals and interventions identified. S#107 confirmed that the care plan had not been updated to provide clear direction to staff.

On September 30, 2015, Inspector #613 met with the LTC Nurse Manager who confirmed that resident had a seat belt while in wheelchair but no longer used bed rails while in bed. The seat belt and bed rails were no longer considered a restraint since September 23, 2015 and were now considered a PASD. The LTC Nurse Manager confirmed that the restraint order had not been discontinued and the care plan had not been updated. The LTC Nurse Manger stated that they were in the process of performing a reassessment and were directing staff to update the care plans and get the doctor to discontinue the restraint. [s. 6. (1) (c)]

3. The licensee has failed to ensure that resident #001 is reassessed and the plan of care was 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, specifically in regards to responsive behaviours.

Inspector #542 completed a health care record review for resident #001. The most current care plan accessible to the direct care staff indicted that resident #001 had responsive behaviour posing a safety risk to their self and others. Inspector #542 observed the resident on numerous occasions throughout the inspection and did not observe any responsive behaviours.

On September 28, 2015, Inspector #542 spoke with S#102. They indicated that resident #001 had responsive behaviors on admission but no longer has any behaviours. Inspector spoke with S#106 and S#107 who also indicated that the resident does not exhibit responsive behaviors anymore. [s. 6. (10) (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 by ensuring that the plan of care sets out clear directions to staff and other who provide direct care to residents #016 and #018 for use of a restraint or PASD, to be implemented voluntarily.

WN #2: 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 failed to ensure that where bed rails are used for residents #016 and #018, steps are taken to prevent resident entrapment, taking in to consideration all potential entrapment zones of entrapment; and other safety issues related to the use of bed rails are addressed, including height and latch reliability.

On September 30, 2015, Inspector #613 met with the LTC Nurse Manger to determine if a bed rail assessment, resident assessed and bed system evaluation had been completed on resident's #016 and #018 beds as current care plans identified the use of bed rails for resident #016 and resident #018. The LTC nurse manager confirmed an assessment was completed on all beds with bed rails last year by maintenance staff. The beds and bed rails have remained the same and no changes had occurred since the assessments.

On the same date at a later time, Inspector #613 met with S#109 who identified they used an article titled, 'The FDA Seven (7) Zones of Bed Entrapment' as a reference to complete bed system evaluations. Inspector requested documentation to demonstrate that the beds with bed rails had been assessed for all potential zones of entrapment. S#109 was unable to provide individual documentation on each bed with bed rails that had been assessed. S#109 confirmed there was no record or documentation to identify that residents #016 or #018 had been assessed and that their bed system was evaluated for all potential zones or height and latch reliability of bed rails. S#109 confirmed that latch reliability was not assessed or evaluated on the bed rails.

Inspector #613 reviewed a policy titled, 'Bed Entrapment Policy' with new start date of April 2014. The policy identifies that resident's with bed rails are to be assessed for bed entrapment in all seven zones. The policy did not identify that other safety issues related to the use of bed rails were addressed, including height and latch reliability of the bed rails. [s. 15. (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 by ensuring that where bed rails are used, steps are taken to prevent resident entrapment, taking in to consideration all potential entrapment zones of entrapment; and other safety issues related to the use of bed rails are addressed, including height and latch reliability for all residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004, exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

Inspector #542 completed a health care record review for resident #004. The most current care plan accessible to the direct care staff indicated that resident #004 had a wound. On September 30, 2015, Inspector spoke with S#107 who indicated that the nurses complete the weekly wound assessments on Point Click Care (PCC) and they will document in the progress notes when the dressing change is completed. Inspector #542 reviewed the Weekly Skin/Wound Assessment Summary on PCC and noted that there was not a completed wound assessment completed on August 28, June 19 and 26, 2015. Inspector #542 also reviewed the progress notes and noted that on August 28, 2015, the nursing staff documented that the dressing to resident #004's wound was completed. [s. 50. (2) (b) (iv)]

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 by ensuring that resident #004 pressure ulcer is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #016 and #017 who were incontinent received an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Inspector #613 completed a health care record review for residents #016 and #017. The most current care plans accessible to the direct care staff indicated that resident's #016 and #017 were both incontinent. Inspector reviewed documentation on point click care and in the paper charts for both residents and was unable to locate an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

On September 28, 2015, Inspector #613 met with S#107 and asked S#107 to show the Inspector where the continence assessments were located for residents experiencing incontinence. S#107 informed the Inspector that continence assessments for residents were recently initiated in April 2015 and only completed on recent resident admissions. S#107 showed the Inspector the continence assessment on point click care that had been completed for another resident on April 28, 2015. Inspector asked S#107 if continence assessments were completed on residents #016 and #017. S#107 confirmed that continence assessments had not been completed on resident #016 or #017.

Inspector #613 reviewed a policy titled, 'Continence Care Protocol' with a new start date of June 2014. The policy identified goals and objectives and step one is to complete an assessment obtaining a history of the resident's incontinence. The policy did not identify to use an assessment instrument that is specifically designed for assessment of incontinence.

On October 1, 2015, Inspector #613 met with the LTC Nurse Manger who confirmed that continence assessments were not completed for residents #016 and #017. The LTC Nurse Manager informed the Inspector that the continence assessments were started in April 2015 but have not been completed on each resident who was incontinent. [s. 51. (2) (a)]

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 by ensuring that residents #016 and #017, who are incontinent received an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 they respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On October 1, 2015, Inspector #542 met with the President of the Residents' Council, who indicated that the home does not generally respond in writing within 10 days of receiving their concerns, however the home will respond verbally. Inspector #542 spoke with S#105, who is the appointed assistant for the Residents' Council who confirmed that the licensee does not respond in writing within 10 days. The Long Term Care Nurse Manager indicated that they respond verbally to the residents as soon as they are made aware of the concern. [s. 57. (2)]

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 by ensuring that a written response is provided to the Residents' Council within 10 days of receiving their advise related to concerns or recommendations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care based on an interdisciplinary assessment of the resident's activity patterns and pursuits

During Stage 1 interviews with residents #016 and #017, they informed Inspector #613 that the home was lacking activities of their interests. Inspector completed a health care record review for residents #016 and #017. The most current care plans accessible to the direct care staff indicated that both residents have little involvement and lack attendance at organized recreation. Inspector was unable to locate an interdisciplinary assessment with respect to resident's #016 and #017's activity patterns and pursuits.

Inspector #613 met with S#103 and S#105 who confirmed assessment for resident's activities patterns and pursuits was not completed on admission or at any other time. S#103 informed the Inspector that S#102 completes an activity pattern question for residents on admission as part of the Behaviour Support Ontario (BSO) on the PIECES of Personhood form but this is not part of the resident's care plan. S#103 and S#105 informed Inspector they encourage all residents to come out of their rooms to attend activities.

On October 1, 2015, Inspector #613 met with the LTC Nurse Manger who confirmed activity assessments are not completed for any residents. The care plans did not identify interdisciplinary assessment of resident's #016 and #017's activity patterns and pursuits. [s. 26. (3) 16.]

WN #7: 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 failed to ensure that each resident of the home had 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 the initial tour of the home, Inspector #542 observed all of the tub and shower rooms of the home. It was noted that each tub and shower room contained numerous unlabelled personal care items such as, combs, brushes and bar soaps (unpackaged and used). All of the items were in used condition.

During Stage 1 observations on September 22 and 23, 2015, Inspector #613 observed unlabelled and used personal care items stored in shared residents' bathrooms for some residents, as follows:

-dentures cups
-toothbrushes
-used foot scrub
-used body cream
-comb

Throughout Stage 2 of this inspection, all the personal care items remained unlabelled. [s. 37. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that all members of the Residents' Council are residents of the long-term care home.

The LTC Nurse Manager informed Inspector #613 that the President of the Residents' Council was not a resident of the long-term care home. Inspector #542 spoke with the President of the Residents' Council who confirmed that they are not a resident of the long-term care home. [s. 56. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Inspector #542 interviewed the President of the Residents' Council who indicated that they did not recall the home seeking the advice of Residents' Council regarding the development or carrying out the satisfaction survey and acting on its results. Inspector spoke with S#105 who indicated that the home does complete a survey and the Residents' Council discusses the results of it. Inspector reviewed the Residents' Council minutes from January 2015 to September 2015 which did not indicate any discussion with regards to the development and carrying out the satisfaction survey or acting on its results. Inspector #542 spoke with the LTC Nurse Manager who confirmed that the licensee does not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee has failed to ensure that they document and make available to the Family Council the results of the satisfaction survey in order to seek the advise of the council about the survey.

Inspector #613 reviewed the Family Council minutes for April, May and June 2015 which did not indicate any discussion with regards to the results of the satisfaction survey in order to seek the advise of the council about the survey. There were no minutes for the summer months and September 2015 minutes were not available.

Inspector met with LTC Nurse Manager who stated they review the satisfaction results with the Family Council. The LTC Nurse Manager was unable to provide documentation to the Inspector that supported that the results were provided to the Family Council in order to seek their advise about the survey.

On September 29, 2015, Inspector #613 met with the President of the Family Council who identified that the licensee had not provided the results of any satisfaction surveys in order to seek the advise of the council about the survey. The President of the Family Council informed the Inspector that the Family Council was shown a food satisfaction survey and the Family Council was asked to review and make recommendations but they have not seen any results from the survey. The Family Council President informed the Inspector that they had never seen the results of any satisfaction surveys and that they had been the President of the Family Council since 2008. [s. 85. (4) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #016 and #018's conditions had been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Prior to September 23, 2015, resident #016 had a bed rail restraint and resident #018 had a bed rail and seat belt restraint.

Inspector #613 reviewed the Restraint Record for residents #016 and #018 for the past three months (July, August and September 2015) and noted that there were various dates and times prior to September 23, 2015 that were blank and did not have any documentation from the PSW or RPN working on various shifts. Inspector noted that the RPN's documented after a 0700 to 1900 shift and 2000 to 0700 shift. Inspector could not

locate initials of registered staff assessing use of restraint at least every eight hours on these records.

Inspector met with S#111 who confirmed the expectation for the registered staff is to sign the form at the end of their 12 hour shift. S#111 stated the restraint form should be signed by the staff member working the shift.

Inspector reviewed a policy titled, 'Restraint Policy' with a new start date of February 2013 which identified that the nurse will reassess the resident and document the rationale for the continued use of the restraint every 12 hours, document such on the flow sheet.

Inspector met with the LTC Nurse Manager to determine if registered staff are expected to sign the restraint flow sheet to demonstrate they are assessing the effectiveness and need for the restraint. The LTC Nurse Manger confirmed that the RPN's are to sign the Restraint Record every shift. Inspector asked for clarification with respect to shift hours. The LTC Nurse Manger stated registered staff are to sign the restraint record every 12 hours. [s. 110. (2) 6.]

2. The licensee has failed to ensure that the documentation on the Restraint Record for residents #016 and #018 include the removal of the device, including time of removal or discontinuance and the post-restraining care.

Prior to September 23, 2015, resident #016 had a bed rail restraint and resident #018 had a bed rail and seat belt restraint.

Inspector #613 reviewed the Restraint Record for residents #016 and #018 for the past three months (July, August and September 2015) and noted that there were various dates and times that were blank and did not have any documentation from the PSW or RPN working on various shifts.

Inspector spoke with S#108 and S#110 to determine what it meant when there were blank spaces on the restraint record form. Both staff members confirmed that the sheet should have been signed daily by a PSW and a RPN working that date to document when the restraints were removed and it is an expectation for staff to sign the restraint record on their scheduled shift.

Inspector reviewed a policy titled, 'Restraint Policy' with a new start date of February

2013 which identified that the nurse(RN and RPN)and Personal Support Worker(PSW) will document: the type of restraint, the rationale, date and time of application, frequency of checks, times that the restraint is applied and removed and the patient/resident's response on the restraint record. [s. 110. (7) 8.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies, and that immediate action is taken if any discrepancies are discovered.

On September 30, 2015, Inspector #613 met with LTC Nurse Manager who confirmed that monthly audits were not completed on the daily count sheet of controlled substances. The LTC Manager informed the Inspector that the home recently obtained a new pharmacy provider in May 2015 and was unaware that a monthly audit was required as the count of controlled substances is done daily at each shift change. [s. 130. 3.]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 15th day of October, 2015

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

Original report signed by the inspector.