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
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
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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
Jun 27, 2014	2014_287548_0013	O-000336-14	Critical Incident System

Licensee/Titulaire de permis

COUNTY OF RENFREW
9 INTERNATIONAL DRIVE, PEMBROKE, ON, K8A-6W5

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

BONNECHERE MANOR
470 ALBERT STREET, RENFREW, ON, K7V-4L5

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

RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 1 and 2, 2014.

During the course of the inspection, the inspector(s) spoke with The Resident, Director of Care, Unit Manager, Registered nursing staff, Restorative Care, Rehabilitation Assistant,Physiotherapist and Personal Support Workers.

During the course of the inspection, the inspector(s) Observed the resident and resident's physical restraining device, observed staff to resident interactions, reviewed the health care record, completed several interviews, reviewed the home's policy: Restraint Use of and Minimizing the Use of Restraints and Personal Assistance Service Devices, SOP#: N-19-008, Dated March 28, 2014. Reviewed the home's investigative notes.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA, 2007 S.O. 2007,c. s. 31. (3) (d), in that the Licensee failed to ensure a physical device for Resident #001 was evaluated for its effectiveness.

Resident #001 arrived at the home on a specified date in March, 2014 in a rental wheelchair with a front closure lap belt, applied. The Resident was seen by a Registered Practical Nurse and the home's Physiotherapist on the day of admission. An admission note on the 24 hour care plan indicates that a lap belt restraint in the wheelchair is required as the resident is always trying to get up out of the chair. A physician order and consent was obtained for the lap belt. A referral was sent to Restorative care on the day of admission.

As indicated in the progress notes the resident had removed the lap belt from around their waist and was found in bed one day after admission. A progress note entry indicates that a consult to Restorative Care was sent for a rear facing belt. The back restraint belt was applied later that day.

On a specified date in March, 2014 there was a second incident. It is documented in the progress note that the resident was found stretched out of the wheelchair and the lap belt around mid- chest.

A third incident happened on a specified date in April, 2014. It is documented in the the progress note that the resident was found hanging from the wheelchair with the seat belt around their neck. The resident was released from the device and lowered to the floor. Resident #001 was assessed by a registered staff member and the resident presented with a reddened mark across the throat but had no complaints of discomfort at the time.

It is noted that the two of the three incidents happened during the evening shifts.

On May 1, 2014 during an interview the S#127 Manager of HM2 unit indicated the registered staff are responsible to monitor the effectiveness of the physical device and she believes that all staff know this. The home's policy: Restraint Use of Minimizing the Use of Restraints and Personal Assistance Service, SOP#: N-19-008, Revision dated: March 28, 2014 supports this statement.

On May 1, 2014 registered staff member S# 110 confirmed that they are expected to

assess the resident's condition and the effectiveness of the physical device every eight hours when the resident is restrained and initial the Treatment Administration Record of this assessment.

On May 2, 2014 during an interview with the DOC she indicated she had no knowledge of the incident that happened on the specified date in March,2014. The DOC confirmed that the expectation was for a referral to Restorative Care for the reassessment of resident condition and there be an evaluation of the effectiveness of the physical device after the incident.

On May 2, 2014 during an interview the S#128 Rehabilitation Assistant confirmed that she did not receive a referral to see the resident after the incident of on a specified date in March, 2014.

Immediately, after the incident in April, 2014 the Resident #001 was placed in a Broda chair and findings from the referral to Restorative care determined that the resident required a 4-point lap belt for a physical device.

The resident was provided the 4-point lap belt on a specified date in April, 2014. On May 2, 2014 during an interview the DOC indicated there had been a waiting period for the resident's own wheelchair and for the installment of the 4-point lap belt.

During an interview on May 2, 2014 with S#129 Personal Support Worker (PSW) and S#128 both indicated the 4 point lap belt meets the resident's needs. S#129 indicated that the resident has had no incident with the new physical device.

After the incidents the home provided training to review the proper application of rear facing restraints with PSWs on two separate occasions.

The home's investigation resulted in the discontinued use of rear facing belts in the home.

The home failed to ensure that the Resident #001's condition was reassessed and the effectiveness of the physical device was evaluated after two incidents, whereas one incident resulted in injury to the resident. [s. 31. (3) (d)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. The Licensee failed to comply with , 2007 S.O. 2007,c.8, 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,(c) clear directions to staff and others who provide direct care to the resident.

Resident #001 arrived at the home on a specified date in March, 2014 in a rental wheelchair with a front closure lap belt, applied. The Resident was seen by a Registered Practical Nurse and the home's Physiotherapist on the day of admission. An admission note on the 24 hour care plan indicates that a lap belt restraint in the wheelchair is required as the resident is always trying to get up out of the chair. A physician order and consent was obtained for the lap belt. A referral was sent to Restorative care on the day of admission.

It is noted that there is an inconsistency in the documentation of the physical restraining device between the physician's order and the Resident's #001 care plan. The resident's care plan dated for a specified date in March, 2014 describes the physical device a as 4-point lap belt whereas, the physician order is for a lap belt.

For the partial month of March, 2014 and for the month of April, 2014 is noted that the documentation on the Treatment Administration Record describes the physical device as a lap belt.

On May 2, 2014 a registered staff member S# 110 confirmed that the assessment completed on the Resident's #001 Treatment Administration Record was for the lap belt.

During an interview on a specified date in May 2,2014 S#129 Personal Support Worker (PSW) confirmed that physical device used for Resident #001 was a lap belt during this time period.

The resident was provided the 4-point lap belt on a certain day in April,2014. On May 2, 2014 during an interview the Director of Care indicated there was a waiting period for the resident's own wheelchair and for the installment of the 4-point lap belt.

As such, the Licensee failed to provide clear direction on the type of physical device used for Resident #001. [s. 6. (1) (c)]

Issued on this 14th day of July, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RUZICA SUBOTIC-HOWELL (548)
Inspection No. / No de l'inspection :	2014_287548_0013
Log No. / Registre no:	O-000336-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 27, 2014
Licensee / Titulaire de permis :	COUNTY OF RENFREW 9 INTERNATIONAL DRIVE, PEMBROKE, ON, K8A-6W5
LTC Home / Foyer de SLD :	BONNECHERE MANOR 470 ALBERT STREET, RENFREW, ON, K7V-4L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHAYNE HOELKE

To COUNTY OF RENFREW, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations;
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations;
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations;
(d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations;
(e) the resident is restrained only for as long as is necessary to address the risk referred to in paragraph 1 of subsection (2);
(f) the method of restraining used is discontinued if, as a result of the reassessment of the resident's condition, one of the following is identified that would address the risk referred to in paragraph 1 of subsection (2):
(i) an alternative to restraining, or
(ii) a less restrictive method of restraining that would be reasonable, in light of the resident's physical and mental condition and personal history; and
(g) any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 31 (3).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan for achieving compliance as it relates to the evaluation of the effectiveness of the physical device. The Licensee is to:
- identify and develop a plan on how members of the interdisciplinary team respond to individual resident care needs and evaluate the effectiveness of a physical restraining device
- train the interdisciplinary team on how to evaluate the effectiveness of a physical restraining device

The plan must be submitted in writing to Ruzica Subotic-Howell, LTCH Inspector at: 347 Preston St. 4th Floor, Ottawa, ON, K1S 3J4 or by fax to: 613-569-9670 on or before July 3, 2014.

Grounds / Motifs :

1. 1. The Licensee has failed to comply with LTCHA, 2007 S.O. 2007,c. s. 31. (3) (d), in that the Licensee failed to ensure a physical device for Resident #001 was evaluated for its effectiveness.

Resident #001 arrived at the home on a specified date in March, 2014 in a rental wheelchair with a front closure lap belt, applied. The Resident was seen by a Registered Practical Nurse and the home's Physiotherapist on the day of admission. An admission note on the 24 hour care plan indicates that a lap belt restraint in the wheelchair is required as the resident is always trying to get up out of the chair. A physician order and consent was obtained for the lap belt. A referral was sent to Restorative care on the day of admission.

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member and the resident presented with a reddened mark across the throat but had no complaints of discomfort at the time.

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The home's investigation resulted in the discontinued use of rear facing belts in the home.

The home failed to ensure that the Resident #001's condition was reassessed and the effectiveness of the physical device was evaluated after two incidents, whereas one incident resulted in injury to the resident. [s. 31. (3) (d)] (548)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 27th day of June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ruzica Subotic-Howell

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