Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 2, 2020	2020_683126_0012	003224-20, 008139-20, 009538-20, 009650-20	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Montfort
705 Montreal Road OTTAWA ON K1K 0M9

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

LINDA HARKINS (126), MANON NIGHBOR (755)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 2020.

During this inspection the following logs were inspected:

Log # 003224-20, Critical Incident (CI) #2886-000004-20 related to an allegation of neglect, staff to resident.
Log #008139 (CI # 2886-000008-20) and log # 009538 (CI #2886-000009-20) related to a falls, which resulted in a significant change in the residents.
Log # 009650-20, Complaint inspection related to care and services (bathing, missing personal item, meal time and infection control)

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Clinical Nurse (CN), several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), the Registered Dietitian (RD), the Resident Services Coordinator (RSC) and the Recreation Manager(RM).

The inspectors observed residents and resident home areas, reviewed resident health care records, observed infection control practices (screening, Personal Protective Equipment, (PPE) availability and usage, observed morning beverage pass and reviewed the skype/window visit schedule.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **2 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	Légende 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was not neglected by staff on a specific date in 2020.

As per O reg. 79/10. s. 5. Neglect is defined as means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A critical incident (CI) was reported by the licensee on a specific month of 2020 for neglect of a resident due to the failure of staff's inaction that jeopardized the health, safety or well-being of resident #002.

During the inspection, Activity Aide (AA) #107 and Housekeeper (HK) #105 stated to have found resident #002, in a tilted position in their wheelchair (w/c) with their sweater sleeves tied in knots limiting their hands movement and the tilted position restraining them to their w/c, resident #002's sleeves were tied for approximately five hours.

During the home's investigation, that commenced on the day of the incident of 2020, it was documented by Office Manager (OM) #113 that the camera footage showed Personal Support Worker (PSW) #110 going in every residents bedroom except resident #002's during their rounds on that same day.

According to the camera footage, Registered Nurse (RN) #109 was seen on that specific date in 2020 leaving resident #002's bedroom. The resident's sleeves were tied in knots and was sitting in the w/c in a tilted position. Resident #002 had an unsteady gait, history of falls, had a lap belt prescribed for agitation and the resident was capable of releasing and wanders in other resident's rooms. RN #109 was not seen on the camera footage to

return to the bedroom, for the remainder of their shift.

During an interview with PSW #111, and according to the licensee's camera footage, in the morning of that specific date in 2020, PSW #111 consulted with PSW #112 about resident #002 and PSW #112 responded by telling PSW #111 to leave resident #002 "like that", in a tilted position, with their sleeves tied in knots. OM #113 documented in the licensee's investigation that the camera footage showed PSW #112 bringing resident #002 back to their bedroom.

The licensee's documentation of the camera footage revealed that HK #105 and AA #107 entered resident #002's bedroom later that morning. During the interview, they both confirmed that resident #002 was found with their sweater sleeves tied in knots and was sitting in the w/c tilted, limiting the resident's freedom of movement. No physician order or other documentation was found to support the use of such interventions, nor were actions taken by staff between a certain period on that specific date in 2020 to monitor the resident's well-being during the use of these undocumented interventions.

The licensee failed to ensure the well-being of resident #002 by the inaction of multiple staff, whom were aware that resident #002 was left sitting in a w/c in a tilted position with his sleeves tied in knots, limiting his movement and jeopardizing his safety. [s. 19. [s. 19. (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 to ensure that the licensee shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: 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:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements are met where a resident is being restrained by a physical device under Ontario regulation 79/10. Long-term care homes act, 2007. Requirements relating to restraining by a physical device 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: 1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

A critical incident (CI) was reported by the licensee on a specific month of 2020 for neglect of a resident due to reclining a resident in a wheelchair without a physician's order, risking harm to the resident.

Housekeeper (HK) #105 found resident #002, on specific date in 2020 at the beginning of their shift, in a wheelchair (w/c) tilted with their sweater sleeves tied in knots, limiting the resident's hands movement. Activity Aide (AA) #107 said that when they entered resident #002's bedroom, the w/c was in such a tilted position that the handles of the w/c were on the bed and the resident's knees were facing the ceiling, restraining the resident in the w/c.

It was documented by the licensee during an interview with Registered Nurse(RN) #109 and Personal Support Worker (PSW) #110, that they stated having seen resident #002's sweater sleeves tied in knots and PSW #108 stated it was to prevent resident #002 from untying their lap belt on specific date and time of 2020. RN #109 witnessed PSW #108 tilt resident #002's w/c to 30 degrees declination.

Resident #002 health care record was reviewed for a specific period in 2020 and no documented physician order was found related to tilt resident #2's w/c.

The licensee failed to ensure that resident #002, had a physician's order to support the use of a tilted w/c as a mean to restraint the movement of resident #002. [s. 110. (2) 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 to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that any device that cannot be immediately released by staff were not be used on resident #002.

O. Reg. 79/10, s.112. States that every licensee of a long-term care home shall ensure that the following devices are not used in the home: 6. Any device that cannot be immediately released by staff.

On a specific date in 2020, resident #002 had been wandering during the night in and out of other resident's bedrooms. Staff attempted to prevent wandering, by restraining resident #002, leaving them sitting in the wheelchair (w/c) in a tilted position, with their sweater sleeves tied in knots limiting their hands movement for approximately 5 hrs.

During the licensee's investigation, that commenced on the day of the incident in 2020, it was documented during an interview with Registered Nurse (RN) #109 and Personal Service Worker (PSW) #110, that they witnessed PSW #108 had tied resident #002's sweater sleeves in knots and said that it was to bring them back to their bedroom. PSW #108 said that they tied resident's sleeves in knots to prevent them from untying their lap belt.

On the day of the incident in 2020, resident reportedly seen with their sweater sleeves tied in knots. Resident #002 had a lap belt ordered as a restraint to prevent fall. No documentation could be found to support the therapeutic benefits of using sweater sleeves as restraints.

The licensee failed to ensure that a prohibited device, in this case, sweater sleeves, were not used to restraint resident #002. [s. 112.]

Issued on this 3rd day of July, 2020

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

Original report signed by the inspector.