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**

Hamilton Service Area Office
119 King Street West, 11th Floor
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Telephone: (905) 546-8294
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119, rue King Ouest, 11iém étage
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Télécopieur: (905) 546-8255


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 4, 2013 | 2013_215123_0014 | H-000320-13,H-000378-13 | Critical Incident System |

**Licensee/Titulaire de permis**

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7

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

FAITH MANOR NURSING HOME
7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7

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

MELODY GRAY (123)

**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): June 7, 11, 12, 13, 14, 17, 18, 19, 20 and 21, 2013**

**Concurrent inspection: #2013_215123_0015, H-000115,H-000330-13**

**During the course of the inspection, the inspector(s) spoke with the Director of Resident Care, the Associate Director of Care, the Behaviour Support Worker, the equipment service person, the equipment sales person, the Occupational Therapist, Registered Staff, Personal Support Workers and residents.**

**During the course of the inspection, the inspector(s) reviewed the home's records including policies and procedures, Restraints/Falls Committee meeting minutes, the equipment service records and staff education records and the resident's records.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**

**Minimizing of Restraining**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend | Legendé |
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | 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.) | 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. |
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**Findings/Faits saillants :**

1. The license failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. The home's records were reviewed including the quarterly Fall/Restraint Committee Meeting minutes. It was noted that during the home's Fall/Restraint Committee meeting which included a physician, the Director of Resident Care (DRC), the Associate Director of Care (ADRC), the Physiotherapist, registered staff and a personal support worker (PSW), all members present were in agreement that the identified resident was not a candidate to use a seatbelt restraint because there was a strong possibility that the resident wold strangle themselves. In the resident's progress notes the physician from the Falls Risk Committee documented that the multidisciplinary recommendations for the resident included the recommendation to avoid use of the restraints, especially seatbelts. Other recommendations made were included in the resident's plan of care. Resident's Trigger Listing and RAP Information #11 related to Falls created by the Occupational Therapist (OT) and Registered Practical Nurse (RPN) indicated that the resident was at a high risk for falls. The resident was referred to the OT related to wheelchair safety and there was a suggestion for a wheelchair alarm. The recommended wheelchair alarm was not included in the resident's care plan. Resident's Trigger Listing and RAP Information # 18 related to Physical Restraints indicate that the resident continues to be at a high risk for fall due to behavior of trying to slide under seatbelt posing increased risk for injury. The resident was found by a staff member sitting on the floor with the seatbelt around their neck and was transferred to hospital. Three days later the resident was again found by a staff member of the home, sitting on the floor with the seatbelt closed around their neck. [s. 6. (2)]

***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. 31: Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the restraining of a resident by a physical device is included in the resident's plan of care only if alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risks. The resident's record was reviewed and was observed to include the Restraint Consent Package. It did not include a Record of Alternative Interventions considered, including the start date/evaluation date and outcome of the alternative interventions. The licensee was requested to provide this information and did not provide the documentation of clear evaluation of alternative measures. [s. 31. (2) 2.]

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
**2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was informed of an injury in respect of which a person is taken to hospital. While reviewing the resident's record in relation to the critical incident it was identified in the record that the resident was transferred to the hospital as a result of an injury sustained from a fall. The home did not inform the Director as required. The Director of Resident Care (DRC) was interviewed and reports that the staff did not inform her of the resident's transfer to hospital and therefore, a report was not submitted to the Director. The inspector requested that the home submit a report to the director as required. [s. 107. (3)]

**WN #4: 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).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
The physician's order for the resident stated: Tilt wheelchair and apply lap belt restraint lateral at back to prevent falls from wheelchair. Resident's care plan reviewed and under the Focus related to restraints: includes: Restrain use related to specific disease processes and notes that the resident has an order for a seat belt applied lateral to back when the w/c (currently using facility w/c which has side release seat belt).
The resident's care plan does not include tilting the resident's wheelchair. Progress notes were reviewed and identified that the resident's seatbelt was removed at times while in wheelchair when she became upset or agitated. Staff interviewed and report that the resident's wheelchair was damaged and had been awaiting repairs for some time. The resident was placed in three different loaned chairs, which did not always have a back-closing seatbelt. The physician's order to tilt the wheelchair and apply lap belt restraint lateral at back was not complied with. [s.110. (2) 1.]

2. The licensee failed to ensure 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. Resident's Medication Administration Records were reviewed and indicated that the resident's condition and the effectiveness of the restraining was not evaluated at least every eight hours by a member of the registered nursing staff. Documentation indicates that the resident's condition and the effectiveness of the restraining was evaluated only twice daily and progress notes indicates that the resident was up in wheelchair with seatbelt late night on occasion. [s. 110. (2) 6.]

Issued on this 4th day of September, 2013

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

M. GRAY

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) :** | MELODY GRAY (123) |
| **Inspection No. / No de l'inspection :** | 2013_215123_0014 |
| **Log No. / Registre no:** | H-000320-13,H-000378-13 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Sep 4, 2013 |
| **Licensee / Titulaire de permis :** | HOLLAND CHRISTIAN HOMES INC<br>7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7 |
| **LTC Home / Foyer de SLD :** | FAITH MANOR NURSING HOME<br>7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | JOHN KALVERDA |

To HOLLAND CHRISTIAN HOMES INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the care set out in the plan of care for all residents with restraints, is based on an assessment of the residents and the needs and preferences of those residents.

**Grounds / Motifs :**

1. The license failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. The home's records were reviewed including the quarterly Fall/Restraint Committee Meeting minutes. It was noted that during the home's Fall/Restraint Committee meeting which included a physician, the Director of Resident Care (DRC), the Associate Director of Care (ADRC), the Physiotherapist, registered staff and a personal support worker (PSW), all members present were in agreement that the identified resident was not a candidate to use a seatbelt restraint because there was a strong possibility that the resident wold strangle themselves. In the resident's progress notes the physician from the Falls Risk Committee documented that the multidisciplinary recommendations for the resident included the recommendation to avoid use of the restraints, especially seatbelts. Other recommendations made were included in the resident's plan of care. Resident's Trigger Listing and RAP Information #11 related to Falls created by the Occupational Therapist (OT) and Registered Practical Nurse (RPN) indicated that the resident was at a high risk for falls. The resident was referred to the OT related to wheelchair safety and there was a suggestion for a wheelchair alarm. The recommended wheelchair alarm was not included in the resident's care plan. Resident's Trigger Listing and RAP Information # 18 related to Physical Restraints indicate that the resident continues to be at a high risk for fall due to behavior of trying to slide under seatbelt posing increased risk for injury. The resident was found by a staff member sitting on the floor with the seatbelt around their neck and was transferred to hospital. Three days later the resident was again found by a staff member of the home, sitting on the floor with the seatbelt closed around their neck. (123)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 18, 2013

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

## 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.

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

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 4th day of September, 2013**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** MELODY GRAY

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office