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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 9, 2017	2016_286547_0035	034638-16	Follow up

Licensee/Titulaire de permis

GENESIS GARDENS INC
438 PRESLAND ROAD OTTAWA ON K1K 2B5

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

FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South Limoges ON K0A 2M0

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

LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 28,29,30, 2016

The purpose of this inspection was to follow-up to a compliance order #001 related to the policy to minimize restraints.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Associate Director of Care (ADOC) and the Director of Care (DOC).

In addition the inspector reviewed resident health care records, policy and procedure titled "Minimizing of Restraints" effective date of November 30, 2016, education records for restraints, nursing staffing records, documents of the home's progress report related to this compliance order. The inspector observed aspects of resident care and interactions with staff.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 29.	CO #001	2016_285126_0019	547

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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).

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 has failed to ensure that resident #001's front closing lap belt attached to the wheelchair was applied in accordance with the manufacturer's instructions.

On December 28, 2016 Inspector #547 observed resident #001 to have a four point lap belt applied to the resident under the resident's tray table. The lap belt was loose enabling Inspector #547 to place a closed fist space between the resident's abdomen and the edge of the lap belt.

PSW #100 indicated to Inspector #547 that this lap belt was a restraint and that they monitor it every hour on the flowsheets. PSW #100 indicated that she will tighten the resident's lap belt as it was a bit loose.

On December 30, 2016 resident #001 was observed to have a loosely fitted four point lap belt applied under the resident's tray table.

Resident #001's plan of care indicated the resident utilizes a lap belt attached to the wheelchair for proper positioning and seating that required hourly monitoring.

The ADOC provided a copy of the manufacturers instructions for pelvic support belts used in the home on December 30, 2016 to Inspector #547.The manufacturers instructions stated " this pelvic support belt must be worn tightly fitted across the lower pelvis or thighs at all times. Four point belts may safely be worn across the upper pelvis if secondary straps are anchored to prevent change in position". The ADOC indicated to Inspector #547 that resident #001 was restrained by a lap belt, and that the resident's lap belt will require re-adjustment as it was not fitting snug so that the resident's pelvis was secured. [s. 110. (1) 1.]

2. The licensee has failed to ensure that resident #007's four point lap belt restraint was applied in accordance with the manufacturer's instructions.

Resident #007 was observed by Inspector #547 on December 28, 2016 to be seated in a wheelchair with a four point lap belt applied. The resident's lap belt was noted to be loose whereby Inspector #547 could place a closed fist space between the resident and the lap belt.

On December 28, 2016 Inspector #547 reviewed the resident's plan of care regarding restraints and noted an order for lap belt to wheelchair. The home's documents for monitoring of the restrictive devices: monitoring and repositioning record indicated that the nursing staff monitor the resident hourly for safety.

PSW #101 indicated to Inspector #547 on December 28, 2016 that the resident's lap belt was too loose and would need to be tightened beneath the resident's seat as per the manufacturers instructions. [s. 110. (1) 1.]

3. The licensee has failed to ensure that resident #008's physical device was well maintained.

On December 28, 2016 Inspector #547 observed resident #008 at 1020 hours, seated with a lap belt restraint in a wheelchair. RN #103 indicated to Inspector #547 that she had verified the resident's lap belt restraint that morning and noted it to be properly clasped and the resident was seated comfortably. Upon review of the resident's lap belt at 1020 hours, RN #103 indicated that the lap belt was loose. RN #103 indicated that she could not tighten the lap belt any more as the belt was at the farthest it could be. Upon closer observation of this lap belt, it was noted that the clasp for the lap belt could be pulled away from the resident's abdomen and the resident's lap belt was easily loosened without opening of the clasp. RN #103 then noted that the belt inside the clasp no longer locked.

PSW #101 assigned to restorative care was called into the room to evaluate the resident's lap belt restraint and indicated that the resident's lap belt would need to be repaired as the belt could not be tightened for proper use for this resident.

On December 29, 2016 resident #008 was seated in a wheelchair at the resident's bedside with facial grimace and indicated to the inspector that he/she was uncomfortable. It was noted that the resident's seat belt remained loose and that the clasp to the wheelchair had not been repaired. Inspector #547 asked RN #104 to evaluate the resident as the resident had indicated to the inspector that he/she was not comfortable. RN #104 indicated that she had verified that the resident's lap belt restraint was in place. She indicated that she does not usually pull on the seat belt to verify the positioning of the lap belts and noticed now that it was too loose. PSW #101 arrived and indicated that she was made aware yesterday of the repair of the lap belt restraint and did not have time to evaluate the problem.

PSW #105 and #106 indicated to Inspector #547 that they were all trained to verify lap belt restraints that they could place a flat hand in between the resident's abdomens and the edge of the seat belt and it should be snug to their hand. Both PSW's indicated that if they could not tighten a resident's lap belt restraint, that they are to inform PSW #101 with restorative care, or the registered nursing staff. Neither RN #104 or PSW #101 indicated to Inspector #547 that they were informed that resident #008's lap belt restraint was malfunctioning before it was brought to their attention on December 28, 2016 by the Inspector.

PSW #101 indicated on December 30, 2016 to Inspector #547 that the resident's lap belt restraint was repaired December 29, 2016. [s. 110. (1) 2.]

4. The licensee has failed to ensure that a lap belt restraint applied to resident #003 was ordered by a physician or a registered nurse in the extended class.

On December 28, 2016 Inspector #547 observed resident #003 seated in a wheelchair approximately four inches away from the back of the wheelchair seat with a loosely applied lap belt restraint under a loosely applied tray table restraint. Resident #003 appeared agitated and foot propelling the wheelchair in the hallway.

PSW #100 indicated that the resident has to wear a lap belt as the resident recently had a fall and the resident was agitated this morning. PSW #100 indicated that the resident will require repositioning as the lap belt was too loose.

RPN #102 indicated to Inspector #547 at 1145 hours that she had assessed the resident that morning while providing medications in the dining room and noted that the resident's lap belt was well fastened and had a tray table in place. RPN #102 indicated the resident had a fall a few days ago and required the lap belt now.

Inspector #547 reviewed the resident's physician orders and noted that there was no documented physician order indicating the use of a lap belt restraint however resident #003 was ordered a tray table restraint while in wheelchair. [s. 110. (2) 1.]

5. The licensee has failed to ensure that resident #003's condition was reassessed and the effectiveness of the restraining evaluated by 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.

On December 28, 2016 Inspector #547 observed resident #003 seated in a wheelchair approximately four inches away from the back of the wheelchair seat with a loosely applied lap belt under a loosely applied table top restraint. Resident #003 appeared agitated and foot propelling the wheelchair in the hallway.

RPN #102 indicated to Inspector #547 at 1145 hours that she had assessed the resident that morning while providing medications in the dining room, and noted that the resident's lap belt was fastened and had a tray table in place as the resident had a fall a few days ago, and required the lap belt now. RPN #102 reviewed the resident's medication administration record (MAR) for this monitoring of restraints and noted that no restraints were identified in the MAR for monitoring for this resident.

Inspector #547 reviewed the resident's physician orders and noted that no documented physician order indicated the use of a lap belt restraint however resident #003 was ordered a tray table restraint while in wheelchair and two half rails while in bed. Inspector #547 observed the resident's bedroom to have two half rails attached to the bed while the resident was located in the infirmary room.

The ADOC reviewed the resident's Medication Administration Records for December 2016 and noted that the monitoring by registered nursing staff was not identified as required for these restraints. [s. 110. (2) 6.]

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 home follows the manufacturer's instructions for the monitoring of the resident's restraints, to be implemented voluntarily.

Issued on this 9th day of January, 2017

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

Original report signed by the inspector.