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) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2013_246196_0009
Log No. / Registre no:	S-000062-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 25, 2013
Licensee / Titulaire de permis :	KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT 35 Van Horne Avenue, Box 725, DRYDEN, ON, P8N-2Z4
LTC Home / Foyer de SLD :	PRINCESS COURT PRINCESS STREET, BOX 725, DRYDEN, ON, P8N-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PATRICK BERREY

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
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Ministére de la Santé et des Soins de longue durée

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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

To KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT, 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)

Linked to Existing Order /
Lien vers ordre existant: 2012_211106_0003, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
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).

Order / Ordre :

The 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: 6. All assessment, reassessment and monitoring, including the resident's response.

Grounds / Motifs :

1. The "Restraint Monitoring Forms" for resident #300 for a twelve day time period, were reviewed. The resident was noted as having a restraint applied all twelve of these days. A member of the registered staff initialed the form only 31 of 36 shifts, to indicate that the resident's condition was reassessed and the effectiveness of the restraining evaluated at least every 8 hours, and at any

other time when necessary based on the resident's condition or circumstances. In addition, on a particular day in May 2013, the restraint was recorded as applied at 0600hrs and noted "tolerated well". There were no further notations of the resident's tolerance to this restraint through to 1600hrs that same day.

(196)

2. The "Restraint Monitoring Forms" for resident #200 for an eleven day time period, were reviewed. The resident was noted as having a restraint applied all eleven of these days. A member of the registered staff initialed the form only 29 of 33 shifts, to indicate that the resident's condition was reassessed and the effectiveness of the restraining evaluated at least every 8 hours, and at any other time when necessary based on the resident's condition or circumstances.

(196)

3. The "Restraint Monitoring Forms", for resident #100, for an eleven day time period, were reviewed. The resident was noted as having a restraint applied all eleven of these days. A member of the registered staff initialed the form only 31 of 33 shifts, to indicate that the resident's condition was reassessed and the effectiveness of the restraining evaluated at least every 8 hours, and at any other time when necessary based on the resident's condition or circumstances.

The licensee failed to 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 failed to ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response.

A previous order relating to O.Reg.79/10,s.110(7)6. was issued on February 28, 2013 Inspection #2012_211106_0003. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2014

Ontario

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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

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Order(s) of the Inspector
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Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
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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 25th day of November, 2013

Signature of Inspector / Signature de l'inspecteur : Lauren Tenhunen #191

Name of Inspector / Nom de l'inspecteur : Lauren Tenhunen

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Nov 25, 2013	2013_246196_0009	S-000062-13	Follow up

Licensee/Titulaire de permis

KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT
35 Van Horne Avenue, Box 725, DRYDEN, ON, P8N-2Z4

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

PRINCESS COURT
PRINCESS STREET, BOX 725, DRYDEN, ON, P8N-2Z4

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

LAUREN TENHUNEN (196)

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): May 14, 15, 16, 17, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Person Support Workers (PSW), Residents and family members

During the course of the inspection, the inspector(s) conducted a tour of all home areas, observed the provision of care and services to residents, observed the interactions between staff members and residents, reviewed the licensee's restraint policy, reviewed the health care records of various residents

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

Specifically failed to comply with the following:

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:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

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:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The "Restraint Monitoring Forms" for resident #200 for an eleven day time period, were reviewed. On a particular day in May 2013, the form identified the use of a restraint between the hours of 1400hrs to the time of removal at 2000hrs, specifically noted the safety checks done hourly, notes the resident tolerance, the repositioning and care needs met, but did not indicate the time of the application of the restraint.

The "Restraint Monitoring Forms" for resident #300 for a twelve day time period, were reviewed. On two particular days in May 2013, there was a hand written notation "res. already in restraint at start of shift" in the 0600hrs time slot of the Resident Monitoring Form. There was no documentation to indicate what time the restraint had been applied and by whom.

The licensee failed to 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 failed to ensure that the following was documented: 5. The person who applied the device and the time of application. [s. 110. (7) 5.]

2. The "Restraint Monitoring Forms", for resident #100, for an eleven day time period, were reviewed. The resident was noted as having a restraint applied all eleven of these days. A member of the registered staff initialed the form only 31 of 33 shifts, to indicate that the resident's condition was reassessed and the effectiveness of the restraining evaluated at least every 8 hours, and at any other time when necessary based on the resident's condition or circumstances.

The "Restraint Monitoring Forms" for resident #200 for an eleven day time period, were reviewed. The resident was noted as having a restraint applied all eleven of these days. A member of the registered staff initialed the form only 29 of 33 shifts, to indicate that the resident's condition was reassessed and the effectiveness of the restraining evaluated at least every 8 hours, and at any other time when necessary based on the resident's condition or circumstances.

The "Restraint Monitoring Form" for resident #300 for a twelve day time period, were reviewed. The resident was noted as having a restraint applied all twelve of these days. A member of the registered staff initialed the form only 31 of 36 shifts, to indicate that the resident's condition was reassessed and the effectiveness of the restraining evaluated at least every 8 hours, and at any other time when necessary based on the resident's condition or circumstances. In addition, on a particular day in

May 2013, the restraint was recorded as applied at 0600hrs and noted "tolerated well". There were no further notations of the resident's response to this restraint through to 1600hrs that same day.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee failed to ensure that the following was documented: 6. All assessment, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

3. The "Restraint Monitoring Forms" for two particular days in May 2013 for resident #300 had a hand written notation of "res. already in restraint at start of shift" in the 0600hrs time slot for these particular days. There was no documentation to indicate what time the restraint had been applied, and no documentation of every release of the device and all repositioning.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee failed to ensure that the following was documented: 7. Every release of the device and all repositioning. [s. 110. (7) 7.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 that ensures 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, the person who applied the device and the time of application and every release of the device and all repositioning, to be implemented voluntarily.

Ontario

Ministry of Health and Long-Term Care

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

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THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (3)	CO #001	2012_211106_0003	196

Issued on this 26th day of November, 2013

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

Lauren Lehmen #196