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 prévue 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

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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 17, 2018	2018_740621_0026	007441-17, 010099-17, 014630-17, 018850-17, 026543-17, 029303-17, 008389-18, 009286-18, 014139-18, 017552-18	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 9) GP Inc. as general partner of CVH (No. 9) LP
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Southbridge Roseview
99 Shuniah Street THUNDER BAY ON P7A 2Z2

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

JULIE KUORIKOSKI (621)

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): November 19 - 23, 2018.

The following intakes were completed in this Critical Incident System (CIS) inspection:
- Seven intakes related to falls prevention and management;
- Two intakes related to resident to resident abuse and responsive behaviour management; and
- One intake related to staff to resident abuse and neglect, and restraint utilization.

Complaint inspection #2018_740621_0026 was also conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurse (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Registered Social Worker (RSW), the Nurse Practitioner (NP), the Resident Assessment Instrument (RAI) Coordinator, and residents.

The Inspector also conducted a tour of the resident care areas, reviewed resident care records, staff records, and licensee programs and policies, and observed the delivery of resident care and services, including staff-to-resident and resident-to-resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every 6 months and at any other time when the resident's care needs changed, or care set out in the plan was no longer necessary.

A Critical Incident (CI) was reported by the home to the Director regarding the fall of resident #003 with injury.

On review of specific sections of resident #003's care plan, last revised in October 2018, it identified that this resident utilized a particular mobility aide, required a specific safety device, and required a specified number of staff to assist with a certain type of care activity.

During an interview with resident #003, they identified to Inspector #621 that at the time of inspection, they no longer used a particular mobility aide, as they were able to ambulate with another type of mobility aide; they did not require a certain safety device in place during a certain activity; and did not require staff assistance for a certain care activity. During the interview, the Inspector observed the resident perform a specific activity without staff assist; utilize a certain type of mobility aide, and navigate around a particular safety device, rather than utilize the safety device as it was intended.

During an interview with RPN #109, they reported that RPN staff reviewed and updated care plans at least quarterly, or when there was a significant change in health status. Additionally, RPN #109 stated the unit staff including the PSWs, RPNs and other relevant staff reviewed at least one resident Kardex at every shift, with the team discussing currency of the information and required changes. RPN #109 identified that if staff determined a change was required to the Kardex information, that the RPN on duty would make the necessary changes on the resident's electronic health record, which

would update both the Kardex and corresponding care plan of the resident.

On review of a particular part of resident #003's care plan, RPN #109 reported to Inspector #621 that at the time of inspection, the resident used a different mobility aide that the one identified in the care plan; that the resident was able to complete a certain activity without staff assist; and that use of a particular safety device presented a certain type of safety risk, with the resident now able to perform a certain activity on their own. RPN #109 confirmed that the care plan had not been reviewed and revised to reflect resident #003's current care needs, and should have been.

During an interview with the DOC, they reported to Inspector #621 that it was their expectation that resident care plans were being reviewed at minimum quarterly by the unit PSW and RPN staff, and updated to reflect the resident's current care needs. The DOC reviewed specific sections of resident #003's current care plan at the time of inspection, and confirmed that they did not reflect the resident's current care needs with respect to mobility, falls, and transfer status. [s.6(10)(b)]

2. A Critical Incident (CI) was reported by the home to the Director regarding the fall of resident #004 with injury.

On review of the falls sections of resident #004's care plan, last revised in September 2018, identified that this resident utilized a specific number and type of safety devices.

During an interview with resident #004, they identified to Inspector #621 that at the time of inspection, they used a specific number and type of safety devices when engaged in a particular activity. At the time of the interview, the Inspector observed the resident engaged in the activity, with the same number and type of safety devices in place. The resident also reported to the Inspector that they did not utilize another specific type of safety device and didn't recall ever using that said safety device. On observation, the Inspector did not locate the specific safety device in question.

On review of resident #004's most current falls care plan, RPN #109 reported to Inspector #621 that the resident required only a specified number and type of safety devices when engaged in a certain activity, and did not use the safety device as identified in the resident's care plan. Additionally, RPN #109 indicated that resident #004 did not utilize another type of safety device, and did not recall if such a device had ever been trialled with the resident. RPN #109 further stated that resident #004's most current falls care plans did not reflect the current care needs of this resident with respect to the

and number of specified safety devices discussed.

During an interview with the DOC, they reported to Inspector #621 that it was their expectation that resident care plans were being reviewed at minimum quarterly by the unit PSW and RPN staff, and updated to reflect the resident's current care needs. The DOC reviewed resident #004's the most current falls care plan at the time of inspection, and confirmed that the care plan did not reflect the resident's current care needs with respect to a specified type and number of safety devices, and should have. [s. 6. (10) (b)]

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 resident is reassessed and the plan of care reviewed and revised at least every 6 months and at any other time when the resident's care needs changed, or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy to minimize the restraining of residents and to ensure that any restraining that was necessary, was done in accordance with this Act and the regulations; and ensured that the policy was complied with.

A Critical Incident (CI) was reported by the home to the Director regarding an incident of unauthorized restraint of resident #005.

During a review of the home's policy titled "Least Restraints - RC-22-01-01", last updated February 2017, it identified the following:
- All residents have the right to live in a safe environment, free from restraints.
- The interdisciplinary team may apply a restraint for the protection of the resident who is at high risk of harm to self or others, based on the assessment and judgement of the interdisciplinary team.
- Only use a restraint on a resident after all other alternative means of protecting the resident and/or others have been trialed, evaluated and the resident outcomes documented.
- Only use those devices that Extendicare (Canada) Inc. has approved for restraint use and they will be applied in accordance with the manufacturer's specifications and directions.

During an interview with RPN #108, they reported to Inspector #621 that they had restrained resident #005 using a device that was not an approved restraint; and restrained the resident without discussing with the RN on duty or management to consider alternatives to restraining.

During an interview with the DOC, they confirmed to Inspector #621 that RPN #108 did not follow the home's Least Restraints policy by physically restraining a resident that restricted the resident's freedom of movement; by utilizing a device other than an approved physical restraint; by restraining without a thorough evaluation and documentation of all alternatives to restraining; and by restraining without required orders and consent. [s. 29. (1) (b)]

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 there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary, is done in accordance with this Act and the regulations; and ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident of the home was: 5. Restrained, by use of barriers, locks or other devices or controls, from leaving a room or any part of the home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under common law duty described in section 36.

A Critical Incident (CI) was reported by the home to the Director on a date in April 2018, regarding an incident of unauthorized restraint of resident #005.

During a review of the home's policy titled "Least Restraints - RC-22-01-01", last updated February 2017, it identified the following:
- A physical restraint is any manual method, or any physical or mechanical device, material, or equipment, that is attached or adjacent to the person's body, that the person cannot remove easily, and that does, or has the potential to restrict the resident's freedom movement or normal access to their body.
- Only use those devices that Extendicare (Canada) Inc. has approved for restraint use and they will be applied in accordance with the manufacturer's specifications and directions.
- Approved physical devices may be used within Extendicare homes after a thorough evaluation of all alternatives and based on all the requirements of documentation being met, including: front closing seatbelt; tilt feature, when engaged, on a wheelchair or Geriatric chair; lap boards/trays/table tops on a wheelchair/Geri chair; Full or three-quarter bed side rails used on both open sides of the bed; or One full bed rail or one three-quarter bed rail used and the opposite side of the bed is against the wall.

During an interview with RPN #108, they reported to Inspector #621 that they had restrained resident #005 using a specific device, in a specified area of the home. RPN #108 confirmed that the device used, was not an approved restraint, and that they restrained the resident without discussing with the RN on duty or management to consider alternatives to restraining.

During an interview with the DOC, they confirmed to the Inspector #621 that RPN #108 physically restrained a resident that restricted the resident's freedom of movement and utilized a device other than one approved by the home for use as a physical restraint. [s. 30. (1) 5.]

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 no resident of the home is: 5. Restrained, by use of barriers, locks or other devices or controls, from leaving a room or any part of the home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under common law duty described in section 36, to be implemented voluntarily.

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. (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. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 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 shall ensure that the following were documented: 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; and 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

a) A Critical Incident (CI) was reported by the home to the Director on a day in April 2018, regarding an incident of unauthorized restraint of resident #005.

On review of resident #005's healthcare record, it was identified that on a particular day in April 2018, an order for a specific restraint device was prescribed by NP #102. On further review of the healthcare record, Inspector #621 was unable to locate any documentation for this resident's restraint device.

During an interview with RN #106, they confirmed to Inspector #621 that resident #005 had an order for a specific safety device, utilized as a form of restraint, for approximately one month prior to the death of the resident. RN #106 identified that the decision to restrain the resident was a result of a number of factors including, the resident's visual impairment, falls risk, and responsive behaviours that were not responding well to medication management, and which were putting other residents and themselves at risk.

During an interview with the DOC, they reported to Inspector #621 that resident #005's specific safety device was a form of restraint, and that it was their expectation that restraint documentation had been completed by PSW staff for all device applications between April 23, 2018, when the restraint had been ordered, until May 23, 2018, when the resident was reported to have passed away.

On review of the home's records, the DOC and RAI Coordinator #104 located only a single entry on April 23, 2018 at 1830 hrs identifying PSW #112 as the person who applied the device and the time of its application. The DOC and RAI Coordinator confirmed that no other restraint documentation was found from the period of April 23, and May 23, 2018, and the DOC confirmed that the restraint order had not been discontinued at any time after its initial order on April 23, 2018.

b) During an interview with the DOC, they reported to Inspector #621 that resident #005's specific safety device was a form of restraint, and that it was their expectation that restraint documentation had been completed by PSW and RPN staff for all assessment,

reassessment and monitoring, including the resident's response, between April 23, 2018, (when the restraint had been ordered), until May 23, 2018, (when the resident was reported to have passed away).

On review of the home's records, the DOC and RAI Coordinator #104 located only a single entry on April 23, 2018, at 1830 hrs which identified PSW #112 as the person who determined the restraint was applied and that the resident was checked for safety. The DOC and RAI Coordinator confirmed that no other restraint documentation was found from the period of April 23, and May 23, 2018.

c) During an interview with the DOC, they reported to Inspector #621 that resident #005's specific safety device was a form of restraint, and that it was their expectation that restraint documentation had been completed by PSW and RPN staff for the release of the restraint and all repositioning, between April 23, 2018, (when the restraint had been ordered), until May 23, 2018, (when the resident was reported to have passed away).

On review of the home's records, the DOC and RAI Coordinator #104 located only a single entry on April 23, 2018 at 1830 hrs identifying PSW #112 as the person that observed restraint utilization, including removal and repositioning. The DOC and RAI Coordinator confirmed that no other restraint documentation was found from the period of April 23, and May 23, 2018.

d) During an interview with the DOC, they reported to Inspector #621 that resident #005's specific safety device was a form of restraint, and that it was their expectation that restraint documentation had been completed by PSW and RPN staff for the removal of the device, the time of removal, and post-restraint care, between April 23, 2018, (when the restaint had been ordered), until May 23, 2018, (when the resident was reported to have passed away).

On review of the home's records, the DOC along with RAI Coordinator #104 confirmed that none of the required restraint documentation was found from the period of April 23, and May 23, 2018. [s.110. (7)]

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 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 is documented: 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; and 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care., to be implemented voluntarily.

Issued on this 18th day of December, 2018

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

Original report signed by the inspector.