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 sions 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
Mar 24, 2016	2016_332575_0004	0017733-16	Follow up

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

BELVEDERE HEIGHTS
21 BELVEDERE AVENUE PARRY SOUND ON P2A 2A2

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

LINDSAY DYRDA (575)

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): January 25-29, 2016

This follow-up inspection is related to three compliance orders issued from inspection #2015_376594_0017 related to non-compliance with the home's policy for minimizing of restraining of residents, responsive behaviours, and continence care assessments.

A complaint inspection related to three complaints submitted to the Director regarding the care of residents and operation of the home was conducted concurrently with this inspection. For details, see inspection #2016_332575_0006.

A critical incident inspection related to a resident's fall was also conducted concurrently with this inspection. For details, see inspection #2016_332575_0005.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing Administration (DONA), Associate Director of Resident Care (ADORC), Staff Educator, Program Manager, Program staff, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Food Quality
Responsive Behaviours
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **2 CO(s)**
- **1 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
O.Reg 79/10 s. 53. (4)	CO #002	2015_376594_0017	575

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy for minimizing restraining of residents was in compliance with and was implemented in accordance with applicable requirements under the Act, and was complied with.

Inspector #575 reviewed the home's policy titled 'Policy to Minimize Restraints, NR F 405'. The policy indicated that documentation in the resident's health care record related to the use of restraints is to include: all assessment, reassessment and monitoring including the resident's response; every release of the device and repositioning; and the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. Additionally, the policy indicated that restrained residents must be released and repositioned at least every two hours and when restraints are used, the resident's condition is to be reassessed and the effectiveness of restraining evaluated 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.

The inspector reviewed the health care records of three resident's (two are the same residents identified in the grounds of the two previous compliance orders issued during inspection #2015_376594_0017 and #2014_320576_0007). Restraint monitoring forms and Medication Administration Record/Treatment Administration Records (MAR/TARs) were reviewed for a period of 18 days in 2016, for resident #004, #005, and #006.

From the review, the inspector noted the following:

i) For resident #004, the wrong documentation form was used for seven consecutive days. The 'repositioning form' was used instead of the 'restraint/repositioning form'. The repositioning form did not indicate when the restraint was applied, removed, or released. On one day, there was no documentation of the resident's response, although it was documented that the restraint was in use and the resident was not repositioned every two hours. On another day, there was no documentation if the restraint was in use or the resident's response (however repositioning was documented) and there was no documentation from 1500-2200 hours. On another day, there were periods when the resident's response was not documented and when the restraint was removed. On another day, the resident's response was not documented.

ii) For resident #005, the wrong documentation form was used for one day. The 'repositioning form' was used instead of the 'restraint/repositioning form'. On one day, there was a period when the resident was restrained without being repositioned every two hours (0700-1100 hours). On three days, there were periods of no documentation. On one day, there was no documentation of when the device was removed and on another day, there was no documentation when the restraint was applied or removed.

iii) For resident #006, on three days, there was a period when the resident was restrained without being repositioned every two hours (1200-1500 hours). On two days, there was no documentation of the removal of the device. On two other days, there were periods of no documentation or when the restraint was removed and on two more days, there were periods of no documentation.

A review of the MAR/TAR for these resident's revealed that registered staff did not sign the MAR/TAR to indicate a reassessment was completed on the following days:

Resident #004:
Two day shifts
One evening shift
Two night shifts

Resident #006:
One day shift
Two night shifts

During an interview, the inspector confirmed with the DONA and ADORC, that restraint

monitoring documentation is completed on the restraint/repositioning flow sheet by the PSWs and included all application/removal, repositioning, monitoring and resident responses. The DONA and ADORC also confirmed that the registered nursing staff sign the resident's MAR/TAR each shift (every 8 hours) to indicate that the reassessment was completed.

In addition, the inspector noted the policy did not include the following:
- the duties and responsibilities of staff, including who has the authority to apply or release a physical device and how the home ensures that all appropriate staff are aware at all times when a resident is being restrained by a physical device;
- types of physical devices permitted to be used;
- how consent was to be obtained and where staff are to documented; and
- how alternatives to the use of physical devices are planned and implemented.

The inspector reviewed the policy with the ADORC. The ADORC confirmed that the policy was not clear and did not include the duties and responsibilities of staff, the types of devices permitted to be used, how consent was to be obtained and documented,and how alternatives to the use of physical devices were planned and implemented.

During inspection #2015_376594_0017, a compliance order was issued pursuant to O.Reg 79/10, s 8. (1) regarding the home's policy to minimize the restraining of residents. As part of this order, the licensee was ordered to educate all direct care staff on the home's policy for minimizing the restraining of residents and to ensure that all staff understood the requirements of the policy, with a compliance date of November 16, 2015.

Inspector #575 reviewed the home's training records related to minimizing the restraining of residents. The following topics were outlined:
- Instructor Led: Orientation/Annual
- Surge Policy Review: NR F 405: Policy to Minimize Restraints - Managers and Nursing
- 1:1 Training: Documenting on Restraints, PASDs and Repositioning on POC - PSW
- Excellence in Resident Centered Care

During an interview with the Staff Educator, they indicated that the home's 'Instructor Led: Orientation/Annual' training consisted of a review of the policy via a slide deck, with hands on training. The 'Surge Policy Review: NR F 405: Policy to Minimize Restraints' was assigned to staff with a due date of August 26, 2015, for RNs, RPNs, and PSWs.

For the period of January 1 to December 31, 2015, 54/57 PSWs (2/3 were on leaves of absence) and 14/15 RPNs completed the annual training. For the same period, 45/57 PSWs (1 PSW on leave of absence), 13/15 RPNs, and 5/8 RNs completed the policy review. All staff were not educated on the requirements of the home's policy to minimize the restraining of residents.

Therefore, the licensee failed to ensure that the home's policy to minimize restraining of residents was complied with, in that the documentation indicated restrained residents were not released and repositioned at least every two hours; hourly monitoring and the resident's response of the restraint were not documented on several occasions; application and removal of the restraint was not documented on several occasions; and there were periods of no documentation. The policy did not include all of the requirements as specified in the legislation and the education was not provided to all staff. [s. 8. (1)]

2. The licensee has failed to ensure that the home's Medication Pass policy was complied with.

Inspector #575 reviewed a complaint submitted to the Director in 2015. A family member of resident #010 claimed that they had found medication in resident #010's room on two occasions and that medication was not being administered appropriately.

The inspector interviewed the DONA regarding the accusations. The DONA confirmed that the family had found medications in the resident's room. The DONA indicated that the home was unable to determine how long the medications had been in the resident's room, or when the resident did not take the medications. In an email, a staff member indicated that the resident might have slid the medications in their pocket and that they could not be sure that the resident took their medications.

The inspector reviewed the home's policy titled 'Medication Pass - Procedure', last reviewed June 23, 2014. On page 2, #9, the policy outlined that staff are to administer medications to the resident ensuring that oral medications have been swallowed and staff are not to leave medications at the resident's bedside (unless there was a physician's order to leave at the bedside).

The resident's Medication Administration Record (MAR) was reviewed. The MAR did not indicate for medications to be left at the resident's bedside. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Inspector #575 reviewed resident #008's health care record and observed a paper continence assessment (NR E 303). The inspector noted that the assessment did not include the date of which it was completed, and there were several areas of the assessment that were incomplete.

Two staff were interviewed regarding the date of the assessment, however they were unable to determine when it was completed. RPN #200 indicated that they would assume it was the admission assessment because the home no longer used the paper assessment forms. They further added that all assessments were now completed electronically on Goldcare and have been for at least a period of one year.

Inspector #575 reviewed resident #008's plan of care regarding continence care. The 'ADL Assistance' care plan indicated that the resident was incontinent and interventions identified that the resident required a regular brief during the day and a large brief at night. The 'CCL Assistance' care plan, indicated that the resident was occasionally incontinent and that the resident required a regular brief on days and at night. The resident's most current Resident Assessment Protocol (RAP) assessment indicated that the resident wore a medium pull-up and a brief at night as the resident had an increase in incontinence.

During an interview, the ADORC indicated that the RAP assessment was not correct and the plan of care did not provide clear directions. During an interview with the DONA, they indicated that continence assessments are to be completed upon admission/readmission, quarterly and during any significant change.

During inspection #2015_376594_0017, CO #003 identified that this resident was to receive a continence assessment by November 16, 2015. No assessment had been completed to date. The DONA confirmed to the inspector that the assessment was not completed as required.

In addition, as part of CO #003 issued during inspection #2015_376594_0017, the licensee was ordered to educate all staff who were responsible for completing continence care assessments, with a compliance date of November 16, 2015.

Inspector #575 reviewed the home's training records related to continence care. The following topics were outlined:
-In-service: Continence Care, November 23, 2015
-Bowel Care and Rectal Suppository Administration Certification
-Surge: OANHSS Continence Care and Bowel Management Registered Staff
-Surge: Continence Care and Bowel Management Front-line Staff
-Surge: It's in the Bag - Speciman Collecting like a Champion
-Excellence in Resident Centered Care

During an interview, the DONA indicated that registered staff are responsible for completing the continence assessments.

The inspector interviewed the home's Staff Educator. The Staff Educator indicated that the 'Surge: OANHSS Continence Care and Bowel Management Registered Staff' was

the mandatory education required for registered staff. For the period of January 1 to December 31, 2015, 11/15 RPNs and 6/8 RNs completed the mandatory education. [s. 51. (2) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 plan of care set out clear directions to staff and others who provide direct care to the resident.

Inspector #575 reviewed resident #008's plan of care regarding continence care. The 'ADL Assistance' care plan indicated that the resident was incontinent and interventions identified that the resident required a regular brief during the day and a large brief at night. The 'CCL Assistance' care plan, indicated that the resident was occasionally incontinent and that the resident required a regular brief on days and at night. The resident's most current RAP assessment indicated that the resident wore a medium pull-

up and a brief at night as the resident had an increase in incontinence.

The inspector interviewed PSW #102 regarding how staff receive directions regarding the type of care to provide to a resident. PSW #102 indicated that staff review the resident's care plan and kardex located in the care plan binder at the nursing station. The inspector asked what type of care resident #008 required regarding continence care. The PSW indicated that the resident was incontinent and required a regular brief during the day and a regular brief at night. The PSW reviewed the resident's plan of care, and indicated that the care plan was not clear.

During an interview, the ADORC confirmed that the resident's RAP assessment was not correct and the ADL and CCL care plans provided conflicting care directions and that they were not clear. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Inspector #575 reviewed resident #007's plan of care regarding continence care. Under the 'ADL Assistance' care plan, interventions identified that staff were to encourage the resident to toilet upon waking, after meals and as needed. The 'CCL Assistance' care plan indicated that the resident was on a scheduled toileting plan and staff were to cue the resident to toilet. Both care plans identified that the resident wore a regular brief during the day and a large brief at night. The resident's most current RAP assessment indicated specific toileting interventions and that the resident wore a pull-up during the day and a regular brief at night.

The inspector interviewed PSW #102 regarding how staff receive directions regarding the type of care to provide to a resident. PSW #102 indicated that staff review the resident's care plan and kardex located in the care plan binder at the nursing station. The inspector asked what type of care resident #007 required regarding continence care. The PSW indicated that the resident was incontinent, wore a brief and was not on a toileting plan. The PSW indicated that the staff encourage the resident, however, the resident is not toileted and required a regular brief during the day and a regular brief at night. The PSW reviewed the resident's plan of care, and indicated that the care plan was not clear.

The inspector interviewed PSW #100 regarding the type of care the resident required regarding continence care. PSW #100 indicated that the resident was not toileted and that staff provide brief changes in the morning, before lunch, before supper, at bedtime,

and when needed. PSW #100 indicated that the resident was only toileted at specific times. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

During a inspection completed June 2015, under inspection #2015_376594_0017, it was noted that resident #007 demonstrated responsive behaviours. At the time of the inspection, the resident's plan of care did not provide interventions relating to these behaviours.

Inspector #575 interviewed the ADORC regarding interventions for responsive behaviours for this resident. The ADORC indicated that the resident no longer displayed certain responsive behaviours. The ADORC indicated that medication was prescribed that had been effective in treating these behaviours for this resident.

The inspector reviewed the resident's plan of care. The inspector reviewed progress notes for a period of approximately 10 weeks, with the focus 'behaviour'. During this time, there were three incidents documented of the resident displaying responsive behaviours. The inspector reviewed the resident's care plan and kardex and there were no interventions related to the displayed behaviour. The RAP assessment indicated that the resident continued to display this behaviour and an intervention was in place.

During an interview, PSW #104 stated that they would review the resident's care plan and kardex located at the nursing station for direction on the type of care to provide to a resident.

The RAP assessment indicated that an intervention was in place, however, there were no interventions listed in the care plan and kardex, therefore, the plan of care was not clear. [s. 6. (1) (c)]

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

During an inspection completed in June 2015, under inspection #2015_376594_0017, resident #009 displayed responsive behaviours.

Inspector #575 interviewed the ADORC regarding this resident's behaviours and interventions. The ADORC indicated that since the last inspection, this resident no longer exhibited certain behaviours and interventions in place have been effective.

The inspector reviewed the resident's current plan of care. The inspector noted under 'confusion' and 'risk of injury from falls', a specific intervention involving a device to manage the resident's responsive behaviours to be used at all times. Under 'ADL assistance', the same intervention indicated that the device was only to be used at certain times.

During an interview with PSW #101, they indicated that the device was implemented at certain times only, however, the device was not functioning properly.

During an interview, RPN #200 reviewed the resident's care plan and indicated that the device was currently in use. After the interview, the RPN approached the inspector and stated that the device was discontinued and was no longer an intervention.

The inspector and RPN #200 observed the resident's room and confirmed the device was not in place.

During an interview, the ADORC indicated that the device was implemented when the resident was exhibiting certain responsive behaviours and it was used to notify staff. The ADORC confirmed that the care plan was not updated when the device was removed. The date the device was removed was not determined at the time of inspection. [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 ensuring that the plan of care sets out clear directions to staff and others who provide direct care to resident's #007 and #008, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written description of the Continence Care and Bowel Management program included its:
- goals and objectives;
- relevant policies, procedures, and protocols;
- methods to reduce risk; and
- protocols for referral of residents to specialized resources where required.

Inspector #575 reviewed the home's Continence Care and Bowel Management program provided by the DONA. The inspector noted that the program did not meet the

requirements as described under O.Reg 79/10, s. 30. (1) 1. The inspector noted the following:

i). The program did not include goals and objectives.

ii). Some policies and procedures were not current and directed staff to complete continence assessment NR E 303, which was an old version no longer used by the home.

iii). The program did not include methods to reduce risk, including treatments and interventions to promote continence, strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

iv). Some of the policies and procedures had handwritten comments, items crossed out, and question-marks beside certain interventions.

During an interview, the DONA confirmed that the home's Continence Care and Bowel Management program policies and procedures were not current and had not been updated to reflect the home's current practice. [s. 30. (1) 1.]

2. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Inspector #575 reviewed a complaint regarding resident #011. The complaint indicated that the resident had a medical problem that was not being treated.

The inspector reviewed the resident's plan of care. The resident's care plan indicated that the resident had previously had a certain medical problem. No current interventions were listed. The most recent MDS-RAP assessment indicated that no treatment was required and that the family had provided a treatment for the resident. The Medication Administration Record (MAR) and Treatment Administration Records (TAR) for a period of approximately two months, indicated a treatment to be applied; however, the treatment provided by the family was not indicated on the MAR/TAR.

The inspector interviewed a caregiver for this resident. The caregiver indicated that the resident had a certain medical problem and that staff were currently applying a treatment that was effective. They indicated that they had suggested and tried an intervention in

the past, however, it was not effective.

During an interview, RPN #202 indicated that they were not sure if the medical problem had been diagnosed and that currently a treatment intervention was in place. RPN #202 indicated that an intervention suggested by the family had been tried in the past, however, it was not effective.

During an interview, the ADORC indicated that the previous intervention suggested by the caregiver was not currently being used. The ADORC indicated that the progress notes indicated that in 2013, the caregiver brought in a treatment for the resident, however the ADORC was not able to confirm if it was used or when it was used. The ADORC confirmed that PSWs apply topical medication and it was the expectation that RPNs would sign for it on the MAR/TAR after it was applied.

The inspector reviewed the MAR/TARs for a period of approximately two months and noted that on 16 occasions, the application of the current intervention was not signed for. Through record review, the inspector was not able to determine if the previous intervention brought in by the caregiver was used, when it was used, or the resident's response, however, the caregiver and RPN #202 indicated that it was used previously and it was not effective. [s. 30. (2)]

Issued on this 30th day of March, 2016

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

Original report signed by the inspector.

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDSAY DYRDA (575)
Inspection No. / No de l'inspection :	2016_332575_0004
Log No. / Registre no:	0017733-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 24, 2016
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST 21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2
LTC Home / Foyer de SLD :	BELVEDERE HEIGHTS 21 BELVEDERE AVENUE, PARRY SOUND, ON, P2A-2A2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DONNA DELLIO

To BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST, 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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_376594_0017, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the home's policy for minimizing restraining of residents is in compliance with and is implemented in accordance with applicable requirements under the Act and is complied with.

This plan shall include but not be limited to:

1.) A comprehensive review of the home's policy for minimizing restraining of residents required under section 29 of the Act with revisions made where required, in order to ensure compliance with all elements of the legislative and regulatory requirements as specified under Ontario regulation 109.

2.) This review and revision shall also include the following, at a minimum:

- review of the current restraint/repositioning form;

- the duties and responsibilities of staff, including who has the authority to apply or release a physical device and how the home ensures that all appropriate staff are aware at all times when a resident is being restrained by a physical device;

- types of physical devices permitted to be used;

- how consent is to be obtained and where staff are to document; and

- how alternatives to the use of physical devices are planned and implemented.

3.) Ensuring all staff are provided education and training on the revised policy.

4.) The development and implementation of a daily auditing process to ensure compliance with this policy.

5.) Ensuring that the documentation required when a resident is restrained includes: all assessment, reassessment and monitoring including the resident's response; every release of the device and repositioning; and the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care and is completed as specified in the home's policy for minimizing restraining of residents.

This plan may be submitted in writing to Long-Term Care Homes Inspector Lindsay Dyrda at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the inspector's attention at (705) 564-3133.

This plan must be received by April 6, 2016 and fully implemented by May 4, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's policy for minimizing restraining of residents was in compliance with and was implemented in accordance with applicable requirements under the Act, and was complied with.

During an inspection completed June 2013, under inspection #2013_139163_0018, a compliance order (CO) was issued with a compliance date of September 20, 2013, pursuant to O.Reg 79/10, s. 8. (1) the licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

During a follow-up inspection completed June 2014, under inspection #2014_320576_0007, a CO was re-issued pursuant to the O.Reg 79/10, s. 8. (1) with a compliance date of July 4, 2014.

As a result of an inspection completed in June 2015, under inspection #2015_376594_0017, the CO was re-issued pursuant to the O.Reg 79/10, s. 8. (1) with a compliance date of November 16, 2015.

During this follow-up inspection, Inspector #575 reviewed the home's policy titled 'Policy to Minimize Restraints, NR F 405'. The policy indicated that documentation in the resident's health care record related to the use of restraints is to include: all assessment, reassessment and monitoring including the resident's response; every release of the device and repositioning; and the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. Additionally, the policy indicated that restrained residents must be released and repositioned at least every two hours and when restraints are used, the resident's condition is to be reassessed and the effectiveness of restraining evaluated 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.

The inspector reviewed the health care records of three resident's (two are the same residents identified in the grounds of the two previous compliance orders issued during inspection #2015_376594_0017 and #2014_320576_0007). Restraint monitoring forms and Medication Administration Record/Treatment Administration Records (MAR/TARs) were reviewed for a period of 18 days in 2016, for resident #004, #005, and #006.

From the review, the inspector noted the following:

i) For resident #004, the wrong documentation form was used for seven consecutive days. The 'repositioning form' was used instead of the 'restraint/repositioning form'. The repositioning form did not indicate when the restraint was applied, removed, or released. On one day, there was no documentation of the resident's response, although it was documented that the restraint was in use and the resident was not repositioned every two hours. On another day, there was no documentation if the restraint was in use or the resident's response (however repositioning was documented) and there was no documentation from 1500-2200 hours. On another day, there were periods when the resident's response was not documented and when the restraint was removed. On another day, the resident's response was not documented.

ii) For resident #005, the wrong documentation form was used for one day. The 'repositioning form' was used instead of the 'restraint/repositioning form'. On one day, there was a period when the resident was restrained without being repositioned every two hours (0700-1100 hours). On three days, there were periods of no documentation. On one day, there was no documentation of when the device was removed and on another day, there was no documentation when the restraint was applied or removed.

iii) For resident #006, on three days, there was a period when the resident was restrained without being repositioned every two hours (1200-1500 hours). On two days, there was no documentation of the removal of the device. On two other days, there were periods of no documentation or when the restraint was removed and on two more days, there were periods of no documentation.

A review of the MAR/TAR for these resident's revealed that registered staff did not sign the MAR/TAR to indicate a reassessment was completed on the following days:

Resident #004:
Two day shifts
One evening shift
Two night shifts

Resident #006:
One day shift
Two night shifts

During an interview, the inspector confirmed with the DONA and ADORC, that restraint monitoring documentation is completed on the restraint/repositioning flow sheet by the PSWs and included all application/removal, repositioning, monitoring and resident responses. The DONA and ADORC also confirmed that the registered nursing staff sign the resident's MAR/TAR each shift (every 8 hours) to indicate that the reassessment was completed.

In addition, the inspector noted the policy did not include the following:
- the duties and responsibilities of staff, including who has the authority to apply or release a physical device and how the home ensures that all appropriate staff are aware at all times when a resident is being restrained by a physical device;

- types of physical devices permitted to be used;
- how consent was to be obtained and where staff are to documented; and
- how alternatives to the use of physical devices are planned and implemented.

The inspector reviewed the policy with the ADORC. The ADORC confirmed that the policy was not clear and did not include the duties and responsibilities of staff, the types of devices permitted to be used, how consent was to be obtained and documented,and how alternatives to the use of physical devices were planned and implemented.

During inspection #2015_376594_0017, a compliance order was issued pursuant to O.Reg 79/10, s 8. (1) regarding the home's policy to minimize the restraining of residents. As part of this order, the licensee was ordered to educate all direct care staff on the home's policy for minimizing the restraining of residents and to ensure that all staff understood the requirements of the policy, with a compliance date of November 16, 2015.

Inspector #575 reviewed the home's training records related to minimizing the restraining of residents. The following topics were outlined:
- Instructor Led: Orientation/Annual
- Surge Policy Review: NR F 405: Policy to Minimize Restraints - Managers and Nursing
- 1:1 Training: Documenting on Restraints, PASDs and Repositioning on POC - PSW
- Excellence in Resident Centered Care

During an interview with the Staff Educator, they indicated that the home's 'Instructor Led: Orientation/Annual' training consisted of a review of the policy via a slide deck, with hands on training. The 'Surge Policy Review: NR F 405: Policy to Minimize Restraints' was assigned to staff with a due date of August 26, 2015, for RNs, RPNs, and PSWs.

For the period of January 1 to December 31, 2015, 54/57 PSWs (2/3 were on leaves of absence) and 14/15 RPNs completed the annual training. For the same period, 45/57 PSWs (1 PSW on leave of absence), 13/15 RPNs, and 5/8 RNs completed the policy review. All staff were not educated on the requirements of the home's policy to minimize the restraining of residents.

Therefore, the licensee failed to ensure that the home's policy to minimize

restraining of residents was complied with, in that the documentation indicated restrained residents were not released and repositioned at least every two hours; hourly monitoring and the resident's response of the restraint were not documented on several occasions; application and removal of the restraint was not documented on several occasions; and there were periods of no documentation. The policy did not include all of the requirements as specified in the legislation and the education was not provided to all staff.

The decision to re-issue this non-compliance was based on the severity, scope and history of non-compliance. The severity was determined to be potential for actual harm to resident's who require the use of restraints. The scope was a pattern, affecting all resident's reviewed who required the use of restraints. Despite three previous compliance orders related to this policy, non-compliance continues with this area of legislation. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 04, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_376594_0017, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that resident #008 and any other resident who is incontinent, receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that a specifically designed for assessment of incontinence.

This plan is to include but not be limited to:

1.) A comprehensive review of the home's Continence Care and Bowel Management program with revisions made where required, in order to ensure compliance with all elements of the legislative and regulatory requirements under section 51;

2.) Ensuring all staff who provide direct care to residents are provided education and training in the revised program and policies;

3.) The development and implementation of a process to ensure that registered staff who complete continence care assessments, review the plans of care once developed to ensure directions provide clear and specific resident focused interventions for continence care; and

4.) The development and implementation of a process to audit compliance with the home's Continence Care and Bowel Management program, including the completion of assessments for resident's who are incontinent.

This plan may be submitted in writing to Long-Term Care Homes Inspector Lindsay Dyrda at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the inspector's attention at (705) 564-3133.

This plan must be received by April 6, 2016 and fully implemented by May 4, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident who is incontinent received

an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

During an inspection completed June 2015, under inspection #2015_376594_0017, a compliance order (CO) was issued pursuant to O.Reg 79/10, s. 51 (2), the licensee failed to ensure that each resident who is incontinent, received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Inspector #575 reviewed resident #008's health care record and observed a paper continence assessment (NR E 303). The inspector noted that the assessment did not include the date of which it was completed, and there were several areas of the assessment that were incomplete.

Two staff were interviewed regarding the date of the assessment, however they were unable to determine when it was completed. RPN #200 indicated that they would assume it was the admission assessment because the home no longer used the paper assessment forms. They further added that all assessments were now completed electronically on Goldcare and have been for at least a period of one year.

Inspector #575 reviewed resident #008's plan of care regarding continence care. The 'ADL Assistance' care plan indicated that the resident was incontinent and interventions identified that the resident required a regular brief during the day and a large brief at night. The 'CCL Assistance' care plan, indicated that the resident was occasionally incontinent and that the resident required a regular brief on days and at night. The resident's most current Resident Assessment Protocol (RAP) assessment indicated that the resident wore a medium pull-up and a brief at night as the resident had an increase in incontinence.

During an interview, the ADORC indicated that the RAP assessment was not correct and the plan of care did not provide clear directions. During an interview with the DONA, they indicated that continence assessments are to be completed

upon admission/readmission, quarterly and during any significant change.

During inspection #2015_376594_0017, CO #003 identified that this resident was to receive a continence assessment by November 16, 2015. No assessment had been completed to date. The DONA confirmed to the inspector that the assessment was not completed as required.

In addition, as part of CO #003 issued during inspection #2015_376594_0017, the licensee was ordered to educate all staff who were responsible for completing continence care assessments, with a compliance date of November 16, 2015.

Inspector #575 reviewed the home's training records related to continence care. The following topics were outlined:
-In-service: Continence Care, November 23, 2015
-Bowel Care and Rectal Suppository Administration Certification
-Surge: OANHSS Continence Care and Bowel Management Registered Staff
-Surge: Continence Care and Bowel Management Front-line Staff
-Surge: It's in the Bag - Speciman Collecting like a Champion
-Excellence in Resident Centered Care

During an interview, the DONA indicated that registered staff are responsible for completing the continence assessments.

The inspector interviewed the home's Staff Educator. The Staff Educator indicated that the 'Surge: OANHSS Continence Care and Bowel Management Registered Staff' was the mandatory education required for registered staff. For the period of January 1 to December 31, 2015, 11/15 RPNs and 6/8 RNs completed the mandatory education.

The decision to re-issue this CO was based on the severity of the potential for actual harm to resident's who are incontinent and the home's history of non-compliance (NC). Despite previous NC, NC continues with this area of the legislation. (575)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 04, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de sions de longue durée
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.

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
Inspection de sions de longue durée
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 24th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lindsay Dyrda

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