Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 27, 2018	2018_615638_0005	004271-17, 026730-17, 001816-18, 002147-18, 003880-18	Critical Incident System

Licensee/Titulaire de permis

Board of Management for 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

RYAN GOODMURPHY (638), TIFFANY BOUCHER (543)

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): March 6 - 9, 2018.

The following intakes were inspected during this Critical Incident Systems (CIS) inspection;
-One log was related to a critical incident the home submitted to the Director regarding an un-witnessed fall, which resulted in a change in the resident's condition;
-One log was related to a critical incident the home submitted to the Director regarding alleged staff to resident emotional and verbal abuse;
-Two logs were related to critical incidents the home submitted to the Director regarding alleged staff to resident physical abuse; and
-One log was related to a critical incident the home submitted to the Director regarding improper care and the use of a prohibited device for restraining.

A Follow Up inspection #2018_615638_0006, was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing Administration (DONA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant staff personnel files, internal investigation notes, licensee policies, procedures, programs, relevant training and resident health care records.

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.

5 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted to the Director related to an incident where resident #004 was restrained to an assistive mobility device with a prohibited device on a specific date in February 2018. The report indicated that the resident was attempting to get out of their assistive mobility device without assistance and RPN #103 used a prohibited device to restrain the resident. The report indicated that the resident was found to have slid down and the prohibited device was positioned in a manner that was posing a risk to the resident when staff responded and released the resident. Please refer to WN #4 for details.

In an interview with Inspector #638, PSW #104 indicated that they were caring for resident #004 on the date of the incident. The PSW stated that RPN #103 used a prohibited device to restrain the resident to their assistive mobility device to prevent them from rising. The PSW then stated that they responded to resident #004 after PSW #107 noticed the resident had slid down in their assistive mobility device and the prohibited device was positioned in a manner that was posing a risk to the resident and they were notably distressed. PSW #104 indicated that they assumed the RPN had obtained an order for this restraint and did not report the incident to anyone.

During an interview with Inspector #638, PSW #107 indicated that they responded to resident #004, when they noticed the resident had slid down in their assistive mobility device. The PSW indicated that they ran to respond to the resident and had to remove a restraint and a prohibited device restraining the resident to their assistive mobility device to prevent the resident from being harmed. The PSW indicated that using this specific

prohibited device as a restraint was dangerous and posed a risk to the resident.

Inspector #638 interviewed RPN #110 who indicated that they became aware of an incident of improper care four days after the incident occurred, during shift report. The RPN indicated they immediately notified the DONA of the incident, but it should have been reported to management at the time of the incident.

The home’s policy titled “Prevention of Abuse and Neglect ZERO Tolerance - PER-2300” effective date October 2015, indicated that the home is mandated to make reports to the Director for improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. The policy also identified that it is a requirement for a person who has reasonable grounds to suspect that a resident has suffered or may suffer abuse, to report the suspicion and the information on which it is based to the RN, DONA, ADORC or CEO immediately.

In an interview with Inspector #638, the DONA indicated that the use of this specific prohibited device, as a restraint, was considered improper care and they were notified of the incident four days after the incident had occurred. The DONA indicated that improper care should be immediately reported to management as per the home's policy. [s. 20. (1)]

2. A CIS report was submitted to the Director, related to an incident of alleged staff to resident abuse. The CIS report indicated that PSW #105 witnessed PSW #100 perform a physical action to resident #002 to stop them from screaming.

Emotional abuse is defined within the Ontario Regulation (O. Reg.) 79/10 as any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Inspector #543 reviewed the home's internal investigation notes and identified that on a specific date in January 2018, PSW #100 and PSW #105 were providing care to resident #002 and the resident started screaming. In response, PSW #100 performed a physical action to stop them. The notes further identified that PSW #100 had performed the same physical action on two separate occasions. The Inspector identified an interview with PSW #100 in the investigation notes, which verified the physical action performed to resident #002 and that it was considered abuse.

The Inspector reviewed a letter, which identified that the outcome of the investigation substantiated that PSW #100's actions towards resident #002 on the specific date in January 2018, were considered abuse. The letter indicated that the PSW's actions violated the abuse provisions of the Long-Term Care Homes Act and the home's policy to promote zero tolerance of abuse and neglect of residents.

In an interview with Inspector #543, the DOC verified that PSW #100 performed a physical action to resident #002 to stop them from screaming on a specific date in January 2018. The DOC stated that PSW #100's actions were considered abuse and indicated that the PSW had not complied with the home's policy to promote zero toleranc

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 resident #002 and every other resident is protected from PSW #100 and the home's policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan identified and included, at a minimum, any risks the resident may have posed to himself or herself, which included any risks of falling and interventions to mitigate those risks.

A CIS report was submitted to the Director. The report indicated that resident #005 sustained a fall on a specific date in February 2017, which caused an injury, resulting in

the resident being sent to hospital.

Inspector #543 reviewed resident #005’s health care records and identified that the resident sustained a total of eight falls during a one month period between February and March 2017.

The Inspector reviewed the resident’s Minimum Data Set (MDS) Home Care Assessment completed prior to the resident’s admission to the home in 2017. The assessment indicated that resident #005 had a history of falling and had fallen twice within 90 days of the assessment.

Inspector #543 reviewed resident #005’s admission "Falls Bedside Assessment". The assessment indicated that the resident had impaired mobility and gait. The Inspector reviewed the resident's "Fall Risk Assessment" tools completed during admission and again in March 2017, which indicated the resident was a low risk for falls and then a high risk for falls, respectively. The "Fall Risk Assessment" completed in June 2017, indicated the resident was a high risk for falls and was unsafe ambulating.

Inspector #543 reviewed resident #005’s care plan in effect at the time of the falls that occurred between February 2017, and May 2017. The resident's care plan, under the "ADL Assistance" focus, included; various specific interventions, however, the Inspector was unable to identify any focus specifically related to their falls or risk of falls.

The Inspector reviewed the home's policy titled "Falls Prevention and Management Policy - NR G 533" effective date July 2014, indicated that registered staff would determine the resident's level of risk as low or high, and would care plan and treat. Staff would monitor and evaluate the care plan at least quarterly in collaboration with the interdisciplinary team. If the interventions have not been effective in reducing falls, initiate an alternative approach and update as necessary. The policy indicated that registered staff would review the fall preventions strategies and modify the plan of care.

Inspector #543 interviewed the DONA who indicated that resident #005 was admitted to the home in 2017, as a result of their history of falls. The DOC verified that the resident’s care plan implemented at the time of their admission did not address the resident’s risk of falls. They indicated the "Fall Risk Assessment" tool completed on admission, was inaccurate and should have identified that the resident was a high risk for falls. The DOC verified that resident’s #005’s 24-hour care plan should have identified that the resident had a risk of falls and that interventions should have been included in their care plan. [s.

24. (2) 1.]

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 residents' 24-hour admission care plans identifies any risks the resident may pose to themselves, including any risks of falling and interventions to mitigate those risks, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents and what changes and improvements were required to prevent further occurrences.

A CIS report was submitted to the Director related to an alleged incident of staff to resident abuse between PSW #100 and resident #002. Please refer to WN #1 finding 2. for details.

Inspector #638 reviewed the home policy titled "Prevention of Abuse and Neglect ZERO Tolerance - PER-2300" effective date October 2015. The Inspector was unable to identify when the home's policy had previously been evaluated.

In an interview with the DONA, Inspector #638 requested the 2017, annual evaluation and documentation related to the home's policy to promote zero tolerance of abuse and neglect of residents. The DONA indicated that they did not believe the home's policy to promote zero tolerance of abuse and neglect of residents was evaluated in the last year.

During an interview with Inspector #638, the Administrator indicated that they did not complete the evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents in 2017, because they would not have been able to complete the evaluation thoroughly. [s. 99. (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 once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that sheets, wraps, tensors or other types of strips or bandages other than for a therapeutic purpose, were not used in the home to limit movement.

A CIS report was submitted to the Director in February 2018. The report indicated that resident #004 had been physically restrained to their assistive mobility device with a prohibited device on a specific date in February 2018. The CIS report indicated that staff found the resident sliding out of their assistive mobility device and the prohibited device was positioned in a manner that was posing a risk to the resident.

Inspector #638 reviewed resident #004's health care records and identified in the progress notes a notation made four days after the incident. The progress note indicated that a prohibited device had been used as a restraint to prevent resident #004 from falling from their assistive mobility device.

In an interview with Inspector #638, PSW #104 indicated that they were resident #004's primary worker on the date of the incident. The PSW indicated that they requested another staff member to look after the resident so they could complete another task. As a result, RPN #103 used a prohibited device to restrain the resident to keep the resident in

their assistive mobility device. The PSW stated that the usage of this specific prohibited device was not an acceptable restraint to use on a resident.

During an interview with Inspector #638, RPN #110 indicated that they became aware of resident #004 being restrained with a specific prohibited device on a specific date in February 2018. The RPN stated that this prohibited device was not considered an acceptable restraint during any circumstance and reported to management, when they became aware of the incident.

The home's policy titled "Use of a Physical Restraint in a Resident's Plan of Care – NR F 405-3" last revised April 2017, indicated that sheets, tensors or other types of strips of bandages used other than for a therapeutic purpose, were prohibited physical devices. The policy further indicated that any device that cannot be immediately released by staff is never permitted for use on a resident.

In an interview with Inspector #638, the DONA indicated that the identified specific prohibited device was indeed considered a prohibited device for restraining a resident. The DONA indicated that resident #004 did not have any ordered restraints and was not supposed to have a restraint applied at the time of the incident. [s. 112.]

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 sheets, wraps, tensors or any other type of strips or bandages other than for a therapeutic, are not used on resident #004, or any other resident, to limit movement, to be implemented voluntarily.

WN #5: 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 six months and at any other time when the resident's care needs changed or the care set out in the plan was no longer necessary.

A CIS report was submitted to the Director. The report indicated that resident #004 had been physically restrained to their assistive mobility device with a prohibited device during a specific date in February 2018. Please refer to WN #4 for details.

Inspector #638 reviewed resident #004's care plan and identified under their falls risk foci, that the resident used a specific assistive mobility device for mobility and staff were to remind the resident to use their specific assistive mobility device at all times.

The Inspector reviewed the resident's March 2018, MDS assessment which indicated that the resident required extensive assistance and staff physical assistance while ambulating. The assessment further identified that the resident used a different assistive mobility device as their primary mode of locomotion.

During multiple observations on March 7, 2018, the Inspector noted resident #004 in the assistive mobility device identified in the MDS assessment. The Inspector conducted an observation of the resident's room and was unable to locate the specific assistive mobility device identified within the care plan, available for the resident to utilize.

In an interview with Inspector #638, PSW #104 indicated that resident #004 used to mobilize independently with a specific assistive mobility device, but the resident has been in a different assistive mobility device for a couple of weeks, due to a decline in their functioning. The PSW stated that direct care staff refer to a resident's care plan for care interventions and that they would expect that resident #004's new assistive mobility

device would have been identified within their care plan. The Inspector reviewed the care plan with the PSW, who indicated that the previous assistive mobility device should no longer be identified as this was removed from the resident and a different assistive mobility device had been implemented.

During an interview with Inspector #638, RPN #110 indicated that resident #004 recently had a decline in their independence and now used a specific assistive device for mobility because they were not safe using a previously used mobility assistive device anymore. The RPN indicated that when a resident's status changed and new interventions implemented, registered staff were required to review the care plan and update accordingly. RPN #110 stated that resident #004's care plan should have been updated because they no longer used the identified mobility assistive device to mobilize and were not independent with ambulation.

The home's policy titled "Care Monitoring and Palliative Protocols - NR G 502" effective date July 2017, indicated that the RN or RPN will ensure the resident is reassessed and the care plan is reviewed and revised when the resident's care needs change.

In an interview with Inspector #638, the DONA indicated that a resident's entire care plan should have been reviewed and updated when the resident's needs changed. The DONA indicated that the registered staff member on shift at the time should have updated the resident #004's care plan when they implemented a different mobility assistive device and no longer used the mobility assistive device identified within their care plan. [s. 6. (10) (b)]

Issued on this 27th day of March, 2018

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

Original report signed by the inspector.