Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
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Amended Public Copy/Copie modifiée du rapport 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 08, 2021	2021_638542_0020 (A1)	014554-21	Other

Licensee/Titulaire de permis

Chapleau Health Services
c/o Chapleau General Hospital 6 Broomhead Road Chapleau ON P0M 1K0

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

The Bignucolo Residence
c/o Chapleau General Hospital, 6 Broomhead Road P.O. Box 757 Chapleau ON P0M 1K0

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

Amended by JENNIFER LAURICELLA (542) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Please see WN#3 (page 7) of the report. It has been amended to reflect the correct dates, from 2021 to 2020. A copy of the amended report has been attached.

Thank you,

Jennifer Lauricella #542

Issued on this 8 th day of December, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by JENNIFER LAURICELLA (542) - (A1)

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The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): September 13 - 16, 2021.

This was a Sudbury Service Area Office Initiated Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), the Chief Executive Officer (CEO), the Long-Term Care Charge Nurse, Registered Practical Nurses (RPNs), Activation Coordinator, Occupational Therapist (OT), Infection Prevention and Control Lead (IPAC), Behavioural Supports Ontario (BSO) staff, Maintenance staff and Housekeeping staff.

The Inspectors conducted daily observations of the provision of care provided to the residents, reviewed relevant policies and procedures of the home and resident health care records.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Reporting and Complaints
Residents' Council
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.

9 WN(s)
4 VPC(s)
2 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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirement was met with respect to restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff applied the physical device in accordance with any manufacturer’s instructions.

A resident was observed with a restraint applied incorrectly to their chair. The restraint did not have a quick release knot.

The Administrator/Director of Care (DOC), indicated that staff “google” how to apply the restraints to the residents. They did not have the manufacturer’s instructions that detailed the correct application of the device. The Administrator/DOC verified that it had not been applied or fastened correctly to the resident’s chair. Inspector asked them to obtain a copy of the manufacturer’s instructions which was later provided.

The manufacturer’s instructions, included details on how the device was to be applied to someone.

The home's failure to ensure that the restraint was properly applied to the resident caused a potential for significant harm to the resident.

Sources: Observations; interviews with registered staff and the Administrator/DOC; and the manufacturer's instructions for the restraint. [s. 110. (1) 1.]

2. The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: 6. That the resident’s condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time necessary based on the resident’s condition or circumstances.

A resident’s Point of Care (POC) documentation indicated that staff were documenting when the restraint was applied, released and repositioned. There was no documentation of when the resident’s condition was being reassessed and the effectiveness of the restraint being evaluated at least every 8 hours.

The home’s lead on restraints, acknowledged that the home was not documenting the reassessments and effectiveness of the restraint.

The home’s policy, titled, “Restraint Policy” last revised, May 14, 2021, documented that re-evaluation of the restraint use must be done by the clinical team (including the physician) and documented at least every 8 hours (while the restraint was in place) for the first 72 hours following application. Weekly for the first month and quarterly thereafter if the restraint was needed beyond 72 hours.

The home’s failure to reassess the resident’s restraint and the effectiveness of the restraint may have impacted the resident's safety and need for ongoing use of the restraint.

Sources: The resident’s care plan; interview with the lead on Restraints; POC documentation; home’s policy on Restraints. [s. 110. (2) 6.]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

A resident's plan of care included the following; the care plan indicated that two different restraints were to be applied while they were in their chair. The Physician's orders read, three different devices were to be applied when in their chair. The orders also indicated that a restraint or PASD could be applied when needed. The consent for the use of the restraints documented the use of two different devices.

The resident was observed on numerous occasions with one of the listed restraints being utilized while they were in their chair.

The LTC charge nurse confirmed that the plan of care for the resident did not set out clear directions to staff and others who provided direct care to the resident.

The care plan had not provided clear directions to the staff which may have resulted in the incorrect devices being applied.

Sources: The resident's care plan, physicians orders and consent records; interview with the Charge Nurse; observations of resident. [s. 6. (1) (c)]

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 plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that all staff at the home received retraining on Infection Prevention and Control (IPAC).

Ontario Reg. 79/10, s. 219 (1) of the LTCHA, 2007, requires that all staff be retrained on IPAC on an annual basis.

The home's IPAC education sign-off sheets dated for three separate times in December, 2020, did not include all staff who worked in the home.

The home was unable to locate education records related to annual IPAC training for unregistered staff who work in the home.

Several staff identified they could not recall when they received education related to IPAC. The IPAC lead verified that IPAC training was not provided to dietary or housekeeping staff in the home since 2019, and that only registered staff received formal in-house IPAC training in 2020.

Failure to provide annual retraining may result in an increased risk of transmitting infections between residents, between staff and from the community.

Sources: Review of staff attendance records dated December 11, 15 and 16, 2020, and interviews with the IPAC lead and other staff members. [s. 76. (4)]

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 persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training was to be provided to all staff who provided direct care to residents: 5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.

Three Registered Practical Nurses indicated that they received training on how to apply the a specific restraint by their co-workers.

The Administrator/DOC indicated that the staff would “google” how to apply the restraint.

The Administrator/DOC provided the training material that was used to train the staff on the correct application of the specific restraint. There was no information on the application of this type of restraint. The home did not have a copy of the manufacturer’s instructions for the correct application of the restraint.

The home's failure to provide education to the direct care staff on the correct application of the specific restraints, posed a potentially significant risk to the resident.

Sources: Training records, including content of training; interviews with registered staff, OT staff and the Administrator/DOC. [s. 221. (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 for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents: 5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program, specifically related to hand hygiene.

An RPN was observed to administered subcutaneous medication to a resident without performing hand hygiene prior to or post administration of the medication.

Three RPN's portered several residents into the dining room and assisted residents with their meals without performing hand hygiene before or after resident contact.

Another RPN portered a resident without performing hand hygiene before resident contact.

Three RPN's portered several residents into the dining room and assisted

residents with their meals without performing hand hygiene before or after resident contact.

Four staff members identified that staff were to perform hand hygiene as per the home's policy.

Six RPN's failed to participate in the implementation of the IPAC program which may have put the residents at risk for contracting a health care associated infection in the home.

Sources: Inspectors' observations of three RPN's and on two different days, review of the home's policy titled Hand Hygiene (INC 00-08001, Revised August 31, 2021), and interviews with staff. [s. 229. (4)]

2. The licensee has failed to ensure that a hand hygiene program was in place in accordance with the Ontario evidence-based hand hygiene (HH) program, "Just Clean Your Hands" (JCYH) related to staff assisting residents with HH before and after meals.

On two specific days in September, residents were not offered or assisted to perform hand hygiene prior to lunch meal service or prior to leaving the dining room after lunch service.

The home's HH policy (INC 00-08001, Revised August 31, 2021) did not include a process for staff to offer or assist residents to clean their hands before and after a meal.

Staff members indicated they were to assist residents to perform hand hygiene before and after meals.

The failure to have a HH program in place in accordance with evidence-based practices presented a minimal risk to residents related to the possible transmission of infection.

Sources: Inspector's observations of residents in the dining room on two separate days in September, review of the home's Hand Hygiene Policy (INC 00-08001, Revised August 31, 2021), review of the "Just Clean Your Hands" LTCH program implementation guide", and interviews with staff. [s. 229. (9)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.1) The heat related illness prevention and management plan must, at a minimum,
(a) identify specific risk factors that may lead to heat related illness and require staff to regularly monitor whether residents are exposed to such risk factors and take appropriate actions in response; O. Reg. 79/10, s. 20 (1.1).
(b) identify symptoms of heat related illness and require staff to regularly monitor whether residents exhibit those symptoms and take appropriate actions in response; O. Reg. 79/10, s. 20 (1.1).
(c) identify specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents; O. Reg. 79/10, s. 20 (1.1).
(d) include the use of appropriate cooling systems, equipment and other resources, as necessary, to protect residents from heat related illness; and O. Reg. 79/10, s. 20 (1.1).
(e) include a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate. O. Reg. 79/10, s. 20 (1.1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the heat related illness prevention and management plan included at a minimum, a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate.

The home's policy, titled "Heat Intolerance" #LTC-02-08002 did not include a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, and the Family Council of the home.

The home's Administrator/DOC verified that the information was not contained in the home's policy.

The home's failure to include the information in the policy presented a minimal risk to the residents.

Sources: Interviews with the Administrator/DOC and a review of the home's "Heat Intolerance" policy. [s. 20. (1.1) (e)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

Two different maintenance staff were unable to provide documentation to indicate that the home had measured and recorded the air temperature in at least two resident bedrooms in different parts of the home.

The home's policy, titled "Heat Intolerance" #LTC-02-08002 did not contain information regarding the measuring and documenting of air temperatures.

The home's failure to ensure that air temperatures were measured and documented in in at least two resident bedrooms in different areas of the home, presented minimal risk to residents.

Sources: Interviews with the Administrator and CEO, maintenance staff and the homes policy, titled "Heat Intolerance" #LTC-02-08002 last reviewed May 13, 2021. [s. 21. (2) 1.]

2. The licensee has failed to ensure that the temperatures required to be measured were documented at least once every evening or night.

Two different maintenance staff were unable to provide this Inspector with documentation to support that the home had checked the air temperatures at least once every evening or night. They verified that the home had not assessed the temperatures of the home.

The home's failure to ensure that air temperatures were measured and documented at least once every morning, evening or night presented minimal risk to residents.

Sources: Interviews with the Administrator, CEO and maintenance staff, and the home's policy titled "Heat Intolerance" policy #LTC-02-08002 last reviewed May 13, 2021. [s. 21. (3)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when they received a written complaint concerning the care of a resident or the operation of the long-term care home they shall immediately forward it to the Director.

As part of the SSAO II Inspection, the Inspector reviewed the home's complaint process and the last complaint that the home received. A written complaint was received by the home on a specific day in September of 2020, concerning the care of a resident's health status.

The Administrator/DOC revealed that the home did not submit the written complaint to the Director. They further indicated that the home's policy was not updated to include the current legislation.

The home's failure to submit the written complaint to the Director presented minimal harm to the residents.

Sources: Interview with the Administrator/DOC, review of the home's "Patient Complaint/Concern Tracking" document and the home's policy, titled "Patient Concerns." [s. 22. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included; c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; d) the final resolution, if any; e) every date on which any response was provided to the complainant and a description of the response; and f) any response made in turn by the complainant.

The home's "Patient Complaint/Concern Tracking documentation did not include all required information according to the legislation.

The Administrator/DOC verified that the "Patient Complaint/Concern Tracking" document did not contain the required information.

The home's failure to include all of the required information on their tracking form presented minimal risk of harm to the residents.

Sources: Interviews with the Administrator/DOC, record reviews of the home's "Patient Complaint/Concern Tracking" document." [s. 101. (2)]

Issued on this 8 th day of December, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER LAURICELLA (542) - (A1)
Inspection No. / No de l'inspection :	2021_638542_0020 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	014554-21 (A1)
Type of Inspection / Genre d'inspection :	Other
Report Date(s) / Date(s) du Rapport :	Dec 08, 2021(A1)
Licensee / Titulaire de permis :	Chapleau Health Services c/o Chapleau General Hospital, 6 Broomhead Road, Chapleau, ON, P0M-1K0
LTC Home / Foyer de SLD :	The Bignucolo Residence c/o Chapleau General Hospital, 6 Broomhead Road, P.O. Box 757, Chapleau, ON, P0M-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jamie Fiaschetti

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

To Chapleau Health Services, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

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

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

The licensee must comply with O. Reg. 79/10, s. 110 (1).

Specifically, the licensee shall prepare, submit and implement a plan to ensure that all staff who apply physical restraints to the residents, follow the manufacturer's instructions for the device. The plan must include but is not limited to:

- a detailed description of all physical restraints used on residents in the LTC home, ensuring consistent terminology is used to prevent confusion;

- a plan on how the home will ensure that all staff who apply restraints to the residents are trained on the appropriate application of such devices, including who will be responsible for providing the training, name of staff trained, date of the training and the content of the training;

- develop an auditing process to evaluate the proper use of the physical restraints in home, and maintain a record of the audit for one month, and provide to the Inspector when required and

- revise the home's current policy and procedure on restraints to meet the legislative requirements.

Please submit the written plan for achieving compliance for inspection 2020_638542_0020 to Jennifer Lauricella, LTC Homes Inspector, MLTC, by email to SudburySAO.moh@ontario.ca by November 10, 2021.

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

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

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the following requirement was met with respect to restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff applied the physical device in accordance with any manufacturer's instructions.

A resident was observed with a restraint applied incorrectly to their chair. The restraint did not have a quick release knot.

The Administrator/Director of Care (DOC), indicated that staff "google" how to apply the restraints to the residents. They did not have the manufacturer's instructions that detailed the correct application of the device. The Administrator/DOC verified that it had not been applied or fastened correctly to the resident's chair. Inspector asked them to obtain a copy of the manufacturer's instructions which was later provided.

The manufacturer's instructions, included details on how the device was to be applied to someone.

The home's failure to ensure that the restraint was properly applied to the resident caused a potential for significant harm to the resident.

Sources: Observations; interviews with registered staff and the Administrator/DOC; and the manufacturer's instructions for the restraint.

An order was made by taking the following factors into account:

Severity: The home's failure to ensure that the direct care staff applied the physical restraint according to manufacturer's instructions posed actual risk of harm to the resident.

Scope: This was an isolated case as no other residents at the Long-Term Care Home had the same type of physical restraint.

Compliance History: In the past 36 months, the home did not have any non-compliance under O. Reg. 79/10, s. 110 (1).
(542)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 : Nov 17, 2021

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

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 # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 110 (2).

Specifically, the licensee shall ensure that the resident's condition is reassessed and the effectiveness of the restraining is evaluated by a physician, a registered nurse in the extended class attending to the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances and is documented.

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

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

Grounds / Motifs :

1. The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: 6. That the resident's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time necessary based on the resident's condition or circumstances.

A resident's Point of Care (POC) documentation indicated that staff were documenting when the restraint was applied, released and repositioned. There was no documentation of when the resident's condition was being reassessed and the effectiveness of the restraint being evaluated at least every 8 hours.

The home's lead on restraints, acknowledged that the home was not documenting the reassessments and effectiveness of the restraint.

The home's policy, titled, "Restraint Policy" last revised, May 14, 2021, documented that re-evaluation of the restraint use must be done by the clinical team (including the physician) and documented at least every 8 hours (while the restraint was in place) for the first 72 hours following application. Weekly for the first month and quarterly thereafter if the restraint was needed beyond 72 hours.

The home's failure to reassess the resident's restraint and the effectiveness of the restraint may have impacted the resident's safety and need for ongoing use of the restraint.

Sources: The resident's care plan; interview with the lead on Restraints; POC documentation; home's policy on Restraints.

An order was made by taking the following factors into account:

Severity: The home's failure to reassess and to evaluate the effectiveness of the restraint could have resulted in actual harm to the resident.

Scope: The scope was identified as an isolated incident as no other residents with a restraint.

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

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

Compliance History: In the last 36 months, the home did not have any non-compliance under this area of the legislation. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 17, 2021

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8 th day of December, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by JENNIFER LAURICELLA (542) - (A1)

Ontario

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