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

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Inspection de soins 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
Sep 30, 2016	2016_285126_0019	013475-16	Resident Quality Inspection

Licensee/Titulaire de permis

GENESIS GARDENS INC
438 PRESLAND ROAD OTTAWA ON K1K 2B5

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

FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South Limoges ON K0A 2M0

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

LINDA HARKINS (126), GILLIAN CHAMBERLIN (593), JOANNE HENRIE (550), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 15, 16, 17, 18, 19, 22, 23, 24, and 26, 2016

During the Resident Quality Inspection, four follow up to orders, one complaint and two critical incidents were inspected.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Directors of Care (DOC), the Assistant Director of Care, the RAI Coordinator, the Maintenance Manager, the Food Service Supervisor (FSS), the Registered Dietitian (RD), the Activity Manager, the Physiotherapy Assistant (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activities Aide, Housekeeping Aides, Residents and Family Members.

In addition the inspection team, reviewed resident health care records, food production documents including planned menus and resident daily food and fluid intake sheets, resident and family council minutes. Documents related to the home's investigations into two critical incidents reported by the home were reviewed as well as policies and procedures related to Infection Control and Prevention of Abuse. The inspection team observed aspects of resident care and interactions with staff, along with medication administration and several meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Quality Improvement
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **3 VPC(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #003	2015_289550_0025	550
O.Reg 79/10 s. 228.	CO #001	2015_289550_0025	550
O.Reg 79/10 s. 229. (2)	CO #002	2015_289550_0025	550

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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that:
(a) the written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and includes all the requirements set under section 109 of O. Reg. 79/10; and,
(b) the policy is complied with.

This inspection is a follow-up inspection to Compliance Order #004 that was issued on December 23, 2015 with a compliance date of July 22, 2016.

A review of the home's ''Minimization of restraints'' policy revealed that the policy was reviewed by the licensee but is still missing the following subsections, under s. 109 of O. Reg. 79/10:

(c) Restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;
(f) Alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and
(g) How the use of restraining in the home will be evaluated to ensure minimization of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

The inspector reviewed the education that was required to be provided to staff who apply physical devices/PASDs or who monitor residents restrained by physical devices. The education was provided to staff on June 21 and 22, 2016 and it was noted that the content of the education that was provided did not include the potential dangers of physical devices or PASDs as specified in the Compliance Order served on December 30th, 2015. Furthermore, the inspector reviewed the attendance for the two education sessions and noted that out of 91 employees, 7 employees (1 RN, 1 RPN, 3 regular PSWs and 2 on-call PSWs) did not receive the education.

As part of the compliance order, the licensee was also required to review and update the written plan of care for each resident restrained by a physical device and or PASD and consider and document alternatives to the use of physical devices for resident # 004, #031 and #037. The inspector reviewed the health care records and written plan of care for residents #004, #031, #037 plus residents #008, #010 and #015. The following areas of non-compliance were identified:

Resident #004 (see WN#5, about s.6 (1) (c) of the LTCHA, 2007):

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #004.

Resident #004 was observed by Inspector #550 at various times throughout the inspection and resident # 004 was observed having a front closure lap belt applied when sitting in the wheelchair.

The documentation in the monitoring/repositioning record for the month of August 2016 and interview with PSW #S111 and the ADOC confirmed that resident #004 has a lap belt applied at all times when sitting in the wheelchair.

Inspector #550 reviewed the plan of care for resident #004 and observed there was no provision for a lap belt in the plan of care.

The ADOC indicated the lap belt should be documented in the resident's plan of care to provide clear directions to staff and that this was an oversight from her part.

(see WN#11, about r. 110. (2). 2. of O. Reg. 79/10)
The licensee has failed to ensure that staff applies the physical device in accordance with instructions specified by the physician or registered nurse in the extended class.

Resident #004 was observed at various times sitting in a wheelchair with a front closure seat belt. The resident was cognitively unable to remove the seat belt.

The physician order (dated a specific day in January 2014) on the three months medication review, indicated ''lap belt to wheelchair PRN (as needed) for safety and provide rest period''.

It was determined by the inspector through observations, documentation in the monitoring/repositioning record for the month of August 2016 and interview with PSW #S111 and the ADOC that the resident has the lap belt applied at all times when sitting in the wheelchair.

As evidenced above, resident #004's physical device is not applied in accordance with instructions specified by the physician or registered nurse in the extended class.

Resident #008 (see WN#11, about r. 110. (2). 2. of O. Reg. 79/10):

The licensee has failed to ensure that staff applies the physical device in accordance with instructions specified by the physician or registered nurse in the extended class.

The written plan of care indicated that resident # 008 required a lap belt when sitting in the wheelchair because he/she slides off the chair and a tray table is applied when sitting in the wheelchair for meals and convenience. It was determined through resident observations, a review of the monitoring /repositioning record and an interview with PSW #114 that the resident has the tray table applied at all times when sitting in the wheelchair. This has been requested by a family member.

The inspector reviewed the physician's order dated a specific day in August 2016 and observed documented: tray table to wheelchair for meals and convenience only.

As evidenced above, the physical device was not applied in accordance with instructions specified by the physician.

Resident # 010 (see WN#7, about s. 31. (2). 4. Of the LTCHA, 2007):

The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

Resident #010 was observed on several occasions throughout the resident quality inspection by Inspector #550 wearing a front closure lap belt. During an interview, PSW #S115 indicated to the inspector that the resident requires a lap belt when sitting in the wheelchair.

Inspector #550 reviewed resident #010's health care records and observed there was no physician order for the lap belt.

During an interview, the ADOC indicated to the inspector this was an oversight from her part.

(see WN#11, about s. 110. (2). 6. Of O. Reg. 79/10.)
The licensee has failed to ensure that resident #010's condition was reassessed and the effectiveness of the restraining evaluated by a physician or 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 based on the resident's condition or

circumstances.

The resident was observed on several occasions throughout the resident quality inspection wearing a front closure lap belt.

An observation of the medication administration record revealed that the resident's condition and the effectiveness of the restraining were not evaluated by registered staff at least every eight hours.

During an interview, the ADOC indicated to the inspector that registered staff are required to sign the medication administration record each shift to indicate they have reassessed the resident's condition and the effectiveness of the restraining.

Resident # 015 (see WN#5, about s. 6. (10.) (b) of the LTCHA, 2007):

The licensee has failed to ensure that resident #015 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 change or care set out in the plan is no longer necessary.

Inspector #550 reviewed resident #015's health care records. It was observed documented in the physician's order on a specific day in February 2016 that the resident required two bedrails up when in bed. It was also documented on the monitoring/repositioning record for the month of August 2016 that the resident had two bedrails up when in bed.

The actual plan of care indicated the resident requires one bedrail up when in bed.

During an interview, PSW #S114 indicated the resident requires two bedrails up when in bed for safety. The ADOC indicated the requirement for 2 bedrails was changed in February from 1 rail to 2 rails as the resident had multiple falls but the plan of care was not revised to reflect this change.

Resident #031(see WN#11 about r. 110. (2). 6. of O. Reg. 79/10):
The licensee has failed to ensure that resident #031's condition was reassessed and the effectiveness of the restraining evaluated by a physician or 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 based on the resident's condition or circumstances.

Resident #031 was observed wearing a lap belt when sitting in the wheelchair. PSW #S111 indicated to the inspector that the resident requires a seat belt when sitting in the wheelchair because he/she does not remember having a surgery that limit his/her ambulation.

The inspector reviewed the resident's health care records and observed on the medication administration record that the resident's condition and the effectiveness of the restraining was not evaluated by registered nursing staff at least every eight hours.

During an interview, the ADOC indicated to the inspector that the registered nursing staff has to sign the medication administration record every shift to indicate they have reassessed and evaluated the effectiveness of the restraint.

Resident #037 (see WN#5 about s.6. (1). (c) of the LTCHA, 2007):

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #037.

It was observed in resident #037's actual plan of care by Inspector #550 that the resident has a tray table applied when sitting in the wheelchair. During an interview, PSW #S111 indicated that this resident was one of the first residents to be assessed after the home's resident quality inspection last year and that they had determined that there was no use for the tray table and that it was removed at that time.

During an interview, the ADOC indicated that the resident no longer requires a tray table when sitting in the wheelchair, that it has been removed a few months ago and that it should not still be in the plan of care as it does not provide clear directions to staff. This was an oversight from her part. The ADOC indicated that audits were conducted on all residents who have physical devices to ensure that they are in compliance with the home's policy on restraints and the Legislation. She indicated that the above were oversights from her part. She further indicated and it was later confirmed by the Administrator that the assessments of all residents restrained by physical devices and PASD were done using an interdisciplinary approach, that the ADOC was the one who did all of the assessments and audits.

Although it was observed that the home has done a lot of work in regards to their

restraint policy, education of staff and assessing, reviewing and updating resident's care plan, it was determined that more work is required to be completed to achieve compliance as described above.

This area of non-compliance was previously issued as a Director's referral on December 23, 2015. The scope and severity of this non-compliance was reviewed. The fact that the licensee does not have a good policy on physical devices in place, the lack staffs' of education and training on the application, the use and potential dangers of PASDs potentially poses a risk to resident's safety. [s. 29. (1)]

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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions are taken to meet the needs of the resident with responsive behaviours including, assessment, interventions and documentation of the resident's response to the intervention.

Resident # 006 was admitted to the home in a four bed room in 2015 with several diagnoses which included dementia. While inspecting two critical incidents report related to physical altercation involving resident # 006 with two other residents, it was noted that several incidents was documented in the progress notes:

On specific day in June 2016, resident #006 believed that his/her spouse was having an affair with another resident in his/her room and was observed shaking the side rail of resident in bed one. The physician was to be updated as an antipsychotic was recently discontinued. No documentation that the physician was contacted or interventions were implemented on that day.

Three days after the incident of June 2016, resident # 006 was observed grabbing the shoulder of a resident and was shouting at him/her. On this day, the physician was contacted and the anti-psychotic was reordered.

On a specific day in July 2016, during the night shift, resident # 006 was observed being loud and yelling wanting the code for the main entrance. Staff was able to redirect to his/her room. On the day shift, resident # 006 was observed to be hallucinating, agitated and shouting at residents telling them they were stealing his/her cheques. Resident # 006 was also very upset and told the nurse that he/she felt that he/she was in jail.

On a specific day in July 2016, resident # 006 was observed making unpleasant comments about a resident that was sitting at the table.

On a specific day in July 2016 during the day shift, resident # 006 was observed to be upset because he/she indicated that two residents were bullying and laughing at him/her all the time.

On a specific day in July 2016, resident # 006 was observed yelling at a resident, telling him/her to “stop shouting, you are disturbing everybody". A resident approached resident # 006 insulted him/her and resident # 006 reacted by putting up one fist and tried to hit the other resident on the face.

On a specific day in July 2016, on evening shift, resident # 006 was observed to be very confused and was checking the phone book to try and found his/her name and he/she could not find it, resident # 006 became aggressive and threw the book on the front desk. Later that evening, resident # 006 was observed to be calmer.

On a specific day in July 2016, resident # 006 assaulted resident # 005 causing an injuries and was accusing him/her of sleeping with his /her spouse. On that day, resident # 006 was sent to the hospital for an assessment, upon his/her return that evening, resident # 006 was moved to a private room and new medication was prescribed. In the next few days a referral to the Psycho Geriatric Team was completed and the plan of care was updated on a specific day of August 2016.

Interview with Assistant Director Of Care (ADOC) indicated that she was told by Personal Support Worker (PSW) # 109 about a specific incident in June 2016, three days after it was observed. The ADOC indicated that she had not interviewed anyone else regarding the incident and follow up was not done. Inspector # 126 and ADOC interviewed PSW # 109 who indicated that she had not witnessed the incident but was told by PSW #110 about that incident and that she believed that the nurse was informed. No documentation was noted in the progress notes related to the incident that occurred on that specific day of June 2016. Discussion was held with the DOC and indicated that she was not aware of that specific incident of June 2016 involving resident # 006.

Resident # 06 was exhibiting responsive behaviors in June and July, 2016 and the licensee failed to ensure that actions were taken to meet the needs of the resident with responsive behaviours including, assessment, interventions and documentation of the resident's response. [s. 53. (4) (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 resident # 006's responsive behaviors actions are taken to meet the needs of the resident including, assessment, interventions and documentation of the resident's response to the intervention., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Inspector #547 interviewed resident #011, the previous President of Resident's Council regarding response to the council by the Licensee regarding concerns or recommendations. Resident #011 indicated that the home does not provide any written responses and that the Assistant will complete the minutes and keep them in a binder in her office and post a copy on the bulletin board.

Upon review of the minutes of the resident's council, it was noted that:

The December 10th, 2016 minutes indicated that residents requested more pancakes and over-easy eggs. Response was provided to the Resident Council on December 23, 2015 thirteen days later and did not include any response related to pancakes or eggs.

The March 31st, 2016 minutes indicated residents were tired of sandwiches and want more variety on the menus. Response to resident's council was provided on April 20, 2016, 20 days after resident's council raised these concerns.

The June 28th, 2016 minutes indicated residents identified concerns regarding meals including the following:

Residents would like soda biscuits with their soup because most of the time they don't give it.
Most of the time, they don’t show the two choices meal and dessert.
The cup of coffee is too small and don't offer refills.
They would like fresh fruits of the seasons on regular basis and also fresh vegetables.
Most of the residents mentioned that when they do not like the two choices they refuse to eat.

The Food Services Supervisor (FSS) indicated to Inspector #547 that she had not had a chance to respond to these concerns.

The Resident Council is not provided response to concerns within the 10 days as required. [s. 57. (2)]

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 a response is provided in writing within 10 days of receiving Resident's Council advice related to concerns and recommendations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that included course by course service of meals for each resident.

During the lunch meal service, August 15, 2016, Inspector #593 observed dessert beginning to be served to residents in the main dining room. Most residents were still observed to be finishing the main course and 11 residents were observed to be served their dessert while still eating their main course. Two of the residents served dessert were observed to eat their main course and dessert simultaneously.

During the lunch meal service, August 19, 2016, Inspector #593 observed dessert

beginning to be served to residents in the main dining room. Most residents were still observed to be finishing the main course and 14 residents were observed to be served their dessert while still eating their main course.

During the lunch meal service, August 22, 2016, Inspector #593 observed dessert beginning to be served to residents in the main dining room. Most residents were still observed to be finishing the main course and 15 residents were observed to be served their dessert while still eating their main course.

During an interview with Inspector #593, August 26, 2016, the Food Service Supervisor #103 reported that it was the expectation of the home that staff wait for the residents to finish their main, clear the main plates and then serve the dessert afterwards. [s. 73. (1) 8.]

2. The licensee has failed to ensure that the home has a dining and snack service that included appropriate furnishings and equipment in resident dining areas.

During the inspection, Inspector #593 observed four semi-circle dining tables in the main dining room. The remainder of the tables in the main dining room were standard square tables, each seating four residents during the meal service.

During the lunch meal service, August 15, 2016, Inspector #593 observed six residents seated in the dining room at the ends of a semi-circle table, however there was inadequate space at the table for these residents therefore they were seated at the end with no allocated table space. One of the six residents was observed with a wheelchair table top which they were using for their meal.

During the lunch meal service, August 19, 2016, Inspector #593 observed six residents seated in the dining room at the ends of a semi-circle table, however there was inadequate space at the table for these residents therefore they were seated at the end with no allocated table space. Four of the six residents were observed with a wheelchair table top which they were using for their meal.

During the lunch meal service, August 22, 2016, Inspector #593 observed eight residents seated in the dining room at the ends of a semi-circle table, however there was inadequate space at the table for these residents therefore they were seated at the end with no allocated table space. Two of the eight residents were observed with a wheelchair table top which they were using for their meal.

A review of the seating plan for the main dining room, found that table's one, two and seven were a semi-circle table with the seating plan indicating that six residents were assigned to each of these tables.

During an interview with Inspector #593, August 26, 2016, the Food Service Supervisor #103 reported that they were unaware that the semi-circle tables did not have enough room for all the residents allocated to these tables and now that she knows this was a concern, it can be dealt with. [s. 73. (1) 11.]

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 home has a dining and snack service that included course by course service of meals for each resident, 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. (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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 :

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #004.

Resident #004 was observed by Inspector #550 at various times throughout the inspection and resident # 004 was observed having a front closure lap belt applied when sitting in the wheelchair.

The documentation in the monitoring/repositioning record for the month of August 2016 and interview with PSW #S111 and the ADOC confirmed that resident #004 has a lap belt applied at all times when sitting in the wheelchair.

Inspector #550 reviewed the plan of care for resident #004 and observed there was no provision for a lap belt in the plan of care.

The ADOC indicated the lap belt should be documented in the resident's plan of care to provide clear directions to staff and that this was an oversight from her part.
[s. 6. (1) (c)]

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #037.

It was observed in resident #037's actual plan of care by Inspector #550 that the resident has a tray table applied when sitting in the wheelchair. During an interview, PSW #S111 indicated that this resident was one of the first residents to be assessed after the home's resident quality inspection last year and that they had determined that there was no use for the tray table and that it was removed at that time.

During an interview, the ADOC indicated that the resident no longer requires a tray table when sitting in the wheelchair, that it has been removed a few months ago and that it should not still be in the plan of care as it does not provide clear directions to staff. This was an oversight from her part. The ADOC indicated that audits were conducted on all residents who have physical devices to ensure that they are in compliance with the home's policy on restraints and the Legislation. She indicated that the above were oversights from her part. She further indicated and it was later confirmed by the Administrator that the assessments of all residents restrained by physical devices and PASD were done using an interdisciplinary approach, that the ADOC was the one who did all of the assessments and audits.

During an interview, the ADOC indicated that the resident no longer requires a tray table in the wheelchair, that it has been removed a few months ago and that it should not still be in the plan of care as it does not provide clear directions to staff. This was an oversight from her part. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care for resident #008 was provided to the resident as specified in the plan.

A review of resident #008's care plan found that the resident was usually continent of bowel, was participating in a bowel care routine daily and was to be toileted at the same time each day to prevent incontinence.

A review of resident #008's daily flow sheets found that from August 1 to 24, 2016, the resident was toileted six out of 24 days. It was recorded that two of these six days, the resident had a bowel movement. The same two days, it was documented in the MAR, that resident #008 was administered a suppository or a laxative.

During an interview with Inspector #593, August 26, 2016, resident #008 reported that she would prefer to be seated on the toilet for a bowel movement rather than left to void in his/her brief. The resident further indicated that the staff does not ask her/him if he/she needs to be toileted.

During an interview with Inspector #593, August 25, 2016, Personal Support Worker (PSW) #112 reported that they do not toilet resident #008 on evening shift as he/she is only toileted on day shift and usually the resident's family visits the evening and would toilet the resident. PSW # 112 further reported that they would only toilet resident #008 if he/she were to ask.

During an interview with Inspector #593, August 26, 2016, Registered Practical Nurse #113 reported that if resident #008 has not had a bowel movement in three days, then a suppository is given. The suppository is administered early in the morning with resident #008 being toileted afterwards however now mostly voids in the brief.

During an interview with Inspector #593, August 26, 2016, PSW #114 reported that resident #008 was only toileted on the day that she was administered a suppository otherwise they will ask the resident if he/she needed to be toileted and the resident is able to tell them.

During an Interview with Inspector #593, August 26, 2016, the DOC reported that she was unfamiliar with resident #008's bowel routine however bowel re-assessments were done as required and was unsure if resident #008's bowel routine had been re-assessed to better meet her needs.

Resident # 008 was not being toileted as per his/her plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that resident #015 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 change or care set out in the plan is no longer necessary.

Inspector #550 reviewed resident #015's health care records. It was observed documented in the physician's order on a specific day in February 2016 that the resident required two bedrails up when in bed. It was also documented on the monitoring/repositioning record for the month of August 2016 that the resident had two bedrails up when in bed.

The actual plan of care indicated the resident requires one bedrail up when in bed.

During an interview, PSW #S114 indicated the resident requires two bedrails up when in bed for safety. The ADOC indicated the requirement for 2 bedrails was changed in February from 1 rail to 2 rails as the resident had multiple falls but the plan of care was not revised to reflect this change.
The licensee has failed to ensure that resident #015 was reassessed and his/her plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Inspector #550 reviewed resident #015's health care records. It was observed documented in the physician's order on a specific day of February 2016 that the resident required two bedrails up when in bed. It was also documented on the monitoring/repositioning record for the month of August 2016 that the resident had two bedrails up when in bed.

The actual plan of care indicated the resident requires one bedrail up when in bed.

During an interview, PSW #S114 indicated the resident requires two bedrails up when in bed for safety. The ADOC indicated the requirement for 2 bedrails was changed in February from 1 rail to 2 rails as the resident had multiple falls but the plan of care was not revised to reflect this change. [s. 6. (10) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas:
• equipped with locks to restrict unsupervised access to those areas by residents, and
• locked when they are not being supervised by staff

During the home's initial tour on August 15, 2016 at approximately 0945hrs, Inspector #550 observed the following:

The door to access the staff room was not locked. There is a notice on door indicating "keep this door locked at all times". There was one staff member inside. When inspector asked the staff member if door should be locked, the staff member answered she did not know and asked inspector if it should be. Inspector showed her the note on the door indicating the door must be locked, she responded that this note had been posted there because of a wandering resident and that the resident is no longer here. The inspector also observed many staff enter the staff room without having to unlock the door many times throughout the resident quality inspector.

The door to the janitor room 154 was not locked. Inside the inspector observed many hazardous products such as Virex, Solid super impact warewashing detergent, Grease Cutter, Lime Away and Total cleaner and polish.

The door to access the kitchen from the hallway was open and there were no staff inside. The inspector walked through the kitchen and approximately 3 minutes later, food service worker #S104 entered the kitchen from the dining room. When asked if the doors to the kitchen are to be kept closed and locked, she indicated that she always closes and locks the doors when she leaves the kitchen. When inspector asked if she had seen the inspector roaming in the kitchen she indicated she had not. As the inspector left the kitchen, the food service worker left at the same time with a cart and went into the dry storage room with the door closed behind her leaving the door to the kitchen open. She then returned to the kitchen a few minutes later with a cart containing food items.

During an interview, the DOC indicated that the staff room is not a resident care area but the door is never locked as staffs always goes in and out of the room. She further indicated there is no call bell in that room as residents are not supposed to access this area of the home. When inspector informed her of the legislation regarding doors in a home, she indicated remembering that this issue was discussed in the past but that they still keep it unlocked. During a discussion regarding the janitor's room that was observed not locked by the inspector, the DOC indicated she was surprised to hear that this door was not locked as it is to be kept locked at all time because of the toxic products inside.

The Food Service Supervisor indicated to the inspect that whenever there is no staff member present in the kitchen, the doors to the access the kitchen are to be kept closed and locked. Even when staffs are just going across the hall to the dry storage area, the doors are to be kept closed and locked.

As evidenced above, doors leading to non-residential areas are not kept locked when not supervised by staff. [s. 9. (1) 2.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1.The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

Resident #010 was observed on several occasions throughout the resident quality inspection by Inspector #550 wearing a front closure lap belt. During an interview, PSW #S115 indicated to the inspector that the resident requires a lap belt when sitting in the wheelchair.

Inspector #550 reviewed resident #010's health care records and observed there was no physician order for the lap belt.

During an interview, the ADOC indicated to the inspector this was an oversight from her part. [s. 31. (2) 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices such as shaving supplies and equipment are readily available to meet the nursing and personal care needs of the residents.

The inspection team observed five out of twenty female residents to have facial hair present during resident observations.

Resident #001, #003 and #008 were observed to have facial hair to the resident upper lips and chins.
Resident #030 and #038 were observed to have facial hair to the resident chins.

Inspector #547 reviewed the home's process for grooming and hygiene related to facial hair removal, and PSW #100 indicated that residents facial grooming is to be done during baths and that certain resident's had their own razors as the home does not supply razors to residents. PSW #100 provided resident #008 a bath on August 22, 2016 and did not shave the resident's upper lip or chin as the resident does not have a razor. PSW #102 further indicated to Inspector #547 that she had just completed resident #001's bath and had utilized the resident's personal electric razor for facial hair grooming. PSW #100 indicated that a few female residents in the home have their own razors and others go to the hair dresser to have their facial hair waxed.

The Director of Activities indicated to Inspector #547 that she coordinates the resident's appointments with the hairdresser for facial hair removal. Resident #001, #003, #008, #030 and #038 were not identified on this list.

The Director of Care (DOC) indicated to Inspector #547 that the home does not provide razors to residents in the home and that male residents usually have their own razors. The DOC indicated that female residents are not usually approached regarding facial hair, unless the resident's or families bring this concern to the home's attention. As with Resident #001, the family requested to have the resident's facial hair removed, and they were suggested to obtain an electric razor. The DOC further indicated that she was not aware that the home was to provide the residents shaving supplies and equipment. [s. 44.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle reviewed by the Residents' Council.

Resident #011 was the previous President of Resident's Council, indicated to Inspector #547 that she could not recall if the council ever reviewed menus.

The Assistant to Resident's Council indicated to Inspector #547 that she has never brought any menus to review with Resident's Council.

The Food Services Supervisor (FSS) indicated to Inspector #547 that she was not aware of the need to review the menus with Resident's Council as she never attends these meetings. The FSS indicated that she usually sent forward a few questions and comments to have reviewed by the Assistant to Resident's Council, however a complete review of the menus would be more beneficial to the residents. [s. 71. (1) (f)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (6) The licensee shall ensure that the home has,
(b) institutional food service equipment with adequate capacity to prepare, transport and hold perishable hot and cold food at safe temperatures; and O. Reg. 79/10, s. 72 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had institutional food service

equipment with adequate capacity to prepare, transport and hold perishable hot and cold food at safe temperatures.

During the lunch meal service, August 19, 2016, Inspector #593 observed a heated food cart with trays of food ready to be served to residents at 1210h. There were four steel food storage containers observed that were not held in the heated bays of the food cart. The cart was then observed to be taken to the small dining room of the home, where several residents were served their meals. The four steel food storage containers were held on a regular trolley that did not have the function to keep the food warm during the service. It was observed that the food in the four steel storage containers was wieners, beans, chicken and pureed beans. The last resident was served their main meal at 1244h therefore for at least 34 minutes; it was observed that the four steel storage containers of food were not kept warm during the meal service.

During the lunch meal service, August 25, 2016, Inspector #593 observed a heated food cart with meals ready to be served to residents at 1215h. There were three steel food storage containers observed that were not held in the heated bays of the food cart. The cart was then observed to be taken to the small dining room of the home, where several residents were served their meals. The three steel food storage containers were held on a regular trolley that did not have the function to keep the food warm during the service. It was observed that the food in the three steel storage containers was French fries, minced French fries and mashed potato. The last resident was served their main meal at 1250h therefore for at least 35 minutes; it was observed that the three steel storage containers of food were not kept warm during the meal service.

During an interview with Inspector #593, August 22, 2016, Dietary Aide #108 reported that there was not enough room in the heated food cart to store all of the food during the meal service and any excess trays of food were held on a regular cart. When asked about whether there was a process in managing this excess food to ensure it is safe and palatable for the residents, Dietary Aide #108 reported that there was no process to follow. Dietary Aide #108 also confirmed that temperatures of the food were not taken at the end of the meal service.

During an interview with Inspector #593, August 26, 2016, the Food Service Supervisor #103 reported that they were unaware that the heated food cart did not have sufficient room for all of the meal choices during the meal service and confirmed that they have no process to determine if the temperature of the food holds during the meal service or if the residents served last were receiving cold food. [s. 72. (6) (b)]

WN #11: 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. (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:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

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 staff applies the physical device in accordance with instructions specified by the physician or registered nurse in the extended class.

Resident #004 was observed at various times sitting in a wheelchair with a front closure seat belt. The resident was cognitively unable to remove the seat belt.

The physician order (dated a specific day in January 2014) on the three months medication review, indicated "lap belt to wheelchair PRN (as needed) for safety and provide rest period".

It was determined by the inspector through observations, documentation in the monitoring/repositioning record for the month of August 2016 and interview with PSW #S111 and the ADOC that the resident has the lap belt applied at all times when sitting in

the wheelchair.

As evidenced above, resident #004's physical device is not applied in accordance with instructions specified by the physician or registered nurse in the extended class. [s. 110. (2) 2.]

2. The licensee has failed to ensure that staff applies the physical device in accordance with instructions specified by the physician or registered nurse in the extended class.

The written plan of care indicated that resident # 008 required a lap belt when sitting in the wheelchair because he/she slides off the chair and a tray table is applied when sitting in the wheelchair for meals and convenience. It was determined through resident observations, a review of the monitoring /repositioning record and an interview with PSW #114 that the resident has the tray table applied at all times when sitting in the wheelchair. This has been requested by a family member.

The inspector reviewed the physician's order dated a specific day in August 2016 and observed documented: tray table to wheelchair for meals and convenience only.

As evidenced above, the physical device was not applied in accordance with instructions specified by the physician. [s. 110. (2) 2.]

3. The licensee has failed to ensure that resident #010's condition was reassessed and the effectiveness of the restraining evaluated by a physician or 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 based on the resident's condition or circumstances.

The resident was observed on several occasions throughout the resident quality inspection wearing a front closure lap belt.

An observation of the medication administration record revealed that the resident's condition and the effectiveness of the restraining were not evaluated by registered staff at least every eight hours.

During an interview, the ADOC indicated to the inspector that registered staff are required to sign the medication administration record each shift to indicate they have reassessed the resident's condition and the effectiveness of the restraining. [s. 110. (2)

6.]

4. The licensee has failed to ensure that resident #031's condition was reassessed and the effectiveness of the restraining evaluated by a physician or 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 based on the resident's condition or circumstances.

Resident #031 was observed wearing a lap belt when sitting in the wheelchair. PSW #S111 indicated to the inspector that the resident requires a seat belt when sitting in the wheelchair because he/she does not remember having a surgery that limit his/her ambulation.

The inspector reviewed the resident's health care records and observed on the medication administration record that the resident's condition and the effectiveness of the restraining was not evaluated by registered nursing staff at least every eight hours.

During an interview, the ADOC indicated to the inspector that the registered nursing staff has to sign the medication administration record every shift to indicate they have reassessed and evaluated the effectiveness of the restraint. [s. 110. (2) 6.]

Issued on this 15th day of December, 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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDA HARKINS (126), GILLIAN CHAMBERLIN (593), JOANNE HENRIE (550), LISA KLUKE (547)
Inspection No. / No de l'inspection :	2016_285126_0019
Log No. / Registre no:	013475-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 30, 2016
Licensee / Titulaire de permis :	GENESIS GARDENS INC 438 PRESLAND ROAD, OTTAWA, ON, K1K-2B5
LTC Home / Foyer de SLD :	FOYER ST-VIATEUR NURSING HOME 1003 Limoges Road South, Limoges, ON, K0A-2M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Benoit Marleau

To GENESIS GARDENS INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_289550_0025, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Order / Ordre :

1. The licensee shall review and revise their new Minimization of Restraints policy to include the requirements under sections 109, 110 and 111, of O. Reg 79/10 more specifically:
• Restraining under common law duty pursuant to subsection 36 (1) of the LTCHA, 2007 when immediate action is necessary to prevent serious bodily harm to the person or others, s. 109. (c)
• Alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach, s. 109 (f); and
• How the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the LTCHA, 2007 and Regulation 79/10. s. 109 (g).

2. Training on the application, the use and potential dangers of PASDs and the training by physical devices shall be provided to all staff, including the seven employees who did not attend the June 2016 education sessions, who apply physical devices or monitor restraining by physical devices or PASDs in accordance with sections 110 and 111 of O. Regulations 79/10. Records of the above required training and of staff who attended shall be kept by the Licensee.

3. Using an interdisciplinary approach, resident # 004, # 008, #010, #015, #031 and #037's need for restraining by a physical device will be re-assessed, their plan of care will reviewed and updated to provide clear directions to staff and others who provide direct care to these residents; and,

4. As per section 113 of O. Reg. 79/10, monthly audits should be carried out involving members of the multidisciplinary team as appropriate to ensure compliance with the home's revised Minimization of Restraints policy. Results of such audits will be evaluated through the Quality Improvement and Utilization Review System.

Grounds / Motifs :

1. 1. 1. The licensee has failed to ensure that:
(a) the written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and includes all the requirements set under section 109 of O. Reg. 79/10; and,
(b) the policy is complied with.

This inspection is a follow-up inspection to Compliance Order #004 that was issued on December 23, 2015 with a compliance date of July 22, 2016.

A review of the home's ''Minimization of restraints'' policy revealed that the policy was reviewed by the licensee but is still missing the following subsections, under s. 109 of O. Reg. 79/10:

(c) Restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;
(f) Alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and
(g) How the use of restraining in the home will be evaluated to ensure minimization of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

The inspector reviewed the education that was required to be provided to staff who apply physical devices/PASDs or who monitor residents restrained by physical devices. The education was provided to staff on June 21 and 22, 2016 and it was noted that the content of the education that was provided did not include the potential dangers of physical devices or PASDs as specified in the Compliance Order served on December 30th, 2015. Furthermore, the inspector reviewed the attendance for the two education sessions and noted that out of 91 employees, 7 employees (1 RN, 1 RPN, 3 regular PSWs and 2 on-call PSWs) did not receive the education.

As part of the compliance order, the licensee was also required to review and update the written plan of care for each resident restrained by a physical device and or PASD and consider and document alternatives to the use of physical devices for resident # 004, #031 and #037. The inspector reviewed the health care records and written plan of care for residents #004, #031, #037 plus residents #008, #010 and #015. The following areas of non-compliance were identified:

Resident #004 (see WN#5, about s.6 (1) (c) of the LTCHA, 2007):

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #004.

Resident #004 was observed by Inspector #550 at various times throughout the inspection and resident # 004 was observed having a front closure lap belt applied when sitting in the wheelchair.

The documentation in the monitoring/repositioning record for the month of August 2016 and interview with PSW #S111 and the ADOC confirmed that resident #004 has a lap belt applied at all times when sitting in the wheelchair.

Inspector #550 reviewed the plan of care for resident #004 and observed there was no provision for a lap belt in the plan of care.

The ADOC indicated the lap belt should be documented in the resident's plan of care to provide clear directions to staff and that this was an oversight from her part.

(see WN#11, about r. 110. (2). 2. of O. Reg. 79/10)
The licensee has failed to ensure that staff applies the physical device in accordance with instructions specified by the physician or registered nurse in the extended class.

Resident #004 was observed at various times sitting in a wheelchair with a front closure seat belt. The resident was cognitively unable to remove the seat belt.

The physician order (dated a specific day in January 2014) on the three months medication review, indicated "lap belt to wheelchair PRN (as needed) for safety and provide rest period".

It was determined by the inspector through observations, documentation in the monitoring/repositioning record for the month of August 2016 and interview with PSW #S111 and the ADOC that the resident has the lap belt applied at all times when sitting in the wheelchair.

As evidenced above, resident #004's physical device is not applied in accordance with instructions specified by the physician or registered nurse in the extended class.

Resident #008 (see WN#11, about r. 110. (2). 2. of O. Reg. 79/10):

The licensee has failed to ensure that staff applies the physical device in accordance with instructions specified by the physician or registered nurse in the extended class.

The written plan of care indicated that resident # 008 required a lap belt when sitting in the wheelchair because he/she slides off the chair and a tray table is applied when sitting in the wheelchair for meals and convenience. It was determined through resident observations, a review of the monitoring /repositioning record and an interview with PSW #114 that the resident has the tray table applied at all times when sitting in the wheelchair. This has been requested by a family member.

The inspector reviewed the physician's order dated a specific day in August 2016 and observed documented: tray table to wheelchair for meals and convenience only.

As evidenced above, the physical device was not applied in accordance with instructions specified by the physician.

Resident # 010 (see WN#7, about s. 31. (2). 4. Of the LTCHA, 2007):

The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

Resident #010 was observed on several occasions throughout the resident quality inspection by Inspector #550 wearing a front closure lap belt. During an interview, PSW #S115 indicated to the inspector that the resident requires a lap belt when sitting in the wheelchair.

Inspector #550 reviewed resident #010's health care records and observed there was no physician order for the lap belt.

During an interview, the ADOC indicated to the inspector this was an oversight from her part.

(see WN#11, about s. 110. (2). 6. Of O. Reg. 79/10.)
The licensee has failed to ensure that resident #010's condition was reassessed and the effectiveness of the restraining evaluated by a physician or 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 based on the resident's condition or circumstances.

The resident was observed on several occasions throughout the resident quality inspection wearing a front closure lap belt.

An observation of the medication administration record revealed that the resident's condition and the effectiveness of the restraining were not evaluated by registered staff at least every eight hours.

During an interview, the ADOC indicated to the inspector that registered staff are required to sign the medication administration record each shift to indicate they have reassessed the resident's condition and the effectiveness of the restraining.

Resident # 015 (see WN#5, about s. 6. (10.) (b) of the LTCHA, 2007):

The licensee has failed to ensure that resident #015 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 change or care set out in the plan is no longer necessary.

Inspector #550 reviewed resident #015's health care records. It was observed documented in the physician's order on a specific day in February 2016 that the resident required two bedrails up when in bed. It was also documented on the monitoring/repositioning record for the month of August 2016 that the resident had two bedrails up when in bed.

The actual plan of care indicated the resident requires one bedrail up when in bed.

During an interview, PSW #S114 indicated the resident requires two bedrails up when in bed for safety. The ADOC indicated the requirement for 2 bedrails was changed in February from 1 rail to 2 rails as the resident had multiple falls but the plan of care was not revised to reflect this change.

Resident #031(see WN#11 about r. 110. (2). 6. of O. Reg. 79/10):
The licensee has failed to ensure that resident #031's condition was reassessed and the effectiveness of the restraining evaluated by a physician or 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 based on the resident's condition or circumstances.

Resident #031 was observed wearing a lap belt when sitting in the wheelchair. PSW #S111 indicated to the inspector that the resident requires a seat belt when sitting in the wheelchair because he/she does not remember having a surgery that limit his/her ambulation.

The inspector reviewed the resident's health care records and observed on the medication administration record that the resident's condition and the effectiveness of the restraining was not evaluated by registered nursing staff at least every eight hours.

During an interview, the ADOC indicated to the inspector that the registered nursing staff has to sign the medication administration record every shift to indicate they have reassessed and evaluated the effectiveness of the restraint.

Resident #037 (see WN#5 about s.6. (1). (c) of the LTCHA, 2007):

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #037.

It was observed in resident #037's actual plan of care by Inspector #550 that the resident has a tray table applied when sitting in the wheelchair. During an interview, PSW #S111 indicated that this resident was one of the first residents to be assessed after the home's resident quality inspection last year and that they had determined that there was no use for the tray table and that it was removed at that time.

During an interview, the ADOC indicated that the resident no longer requires a tray table when sitting in the wheelchair, that it has been removed a few months ago and that it should not still be in the plan of care as it does not provide clear directions to staff. This was an oversight from her part. The ADOC indicated that audits were conducted on all residents who have physical devices to ensure that they are in compliance with the home's policy on restraints and the Legislation. She indicated that the above were oversights from her part. She further indicated and it was later confirmed by the Administrator that the assessments of all residents restrained by physical devices and PASD were done using an

interdisciplinary approach, that the ADOC was the one who did all of the assessments and audits.

Although it was observed that the home has done a lot of work in regards to their restraint policy, education of staff and assessing, reviewing and updating resident's care plan, it was determined that more work is required to be completed to achieve compliance as described above.

This area of non-compliance was previously issued as a Director's referral on December 23, 2015. The scope and severity of this non-compliance was reviewed. The fact that the licensee does not have a good policy on physical devices in place, the lack staffs' of education and training on the application, the use and potential dangers of PASDs potentially poses a risk to resident's safety. [s. 29. (1)] (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 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 soins 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 soins 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 30th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS

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