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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 6, 2020	2020_621755_0008	002426-20, 004007-20, 012096-20	Critical Incident System

Licensee/Titulaire de permis

Genesis Gardens Inc.
1003 Limoges Road South Limoges ON K0A 2M0

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

MANON NIGHBOR (755), LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 17,18,19,22,23,24,25,26, 2020

The following critical incidents, logs were inspected: # 002426-20 (CI# 2746-000001-20), #004007-20 (CI# 2746-000002-20), # 012096-20 (CI# 2746-000005-20), were related to resident to resident abuse, restraint and unexpected death.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practice Nurses (RPN), Dietitian, Personal Support Workers (PSW).

During the course of this inspection, the inspector(s) also reviewed resident health care records, relevant investigation notes, interviewed staff and observed the provision of care and services to residents, and resident home care environments

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: 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 a physician, registered nurse in the extended class or other person provided for in the regulations ordered or approved the use of a bedrail as a restraining device for resident #001.

LTCHA 2007, s. 31 (2) 4. states that 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.

During an interview with PSW #103, they explained that the resident was in the infirmary room, in bed, the morning of a specific day, when they could hear resident #001 "banging" the bedrails. PSW #103 said that the night shift put the bedrails up at night, because the resident was agitated and stated that the resident wasn't supposed to have bedrails.

During resident's #001's record review, M rails to assist with repositioning, was found in their plan of care. No orders found for approval of the use of M rails or any other type of bedrail. No documented recommendation or approval of bedrails found in resident's record review.

During an interview with RPN #101. They explained that resident was confused and "flailing in bed", "bedrails were up, we had no authorization."

During an interview with ADOC #102, they stated that they spoke with staff and the intent was to restrain resident in bed to prevent a fall. The ADOC #102 also stated that there was no order found to indicate the use of bedrails was supported or recommended in the resident's record by a physician, RN in the extended class or other person provided for in the regulations.

The licensee did not ensure before using the bedrail that they were approved and ordered by, a physician, registered nurse in the extended class or other person provided for in the regulations. s. 31 (2) 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 a physician, registered nurse in the extended class or other person provided
for in the regulations has ordered or approved the use of bedrails or any other physical
device prior to:
a) Applying it to resident
b) Including it in the resident's plan of care, to be implemented voluntarily., to be implemented voluntarily.

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 the written plan of care set out clear directions to staff and others who provide direct care to resident #002.

On a specific day, resident #002 exhibited inappropriate sexual behavior toward another resident. At that time, interventions were implemented to monitor resident #002's behaviors.

Resident #002's health care record was reviewed, and it was noted that the plan of care related to the inappropriate sexual behaviors was not documented between a specific day in February to March 17, 2020, the date where streamlining requirements related to the plan of care were issued for all long-term care homes.

On a specific day, DOC #105, initiated the plan of care related to inappropriate sexual behaviors and added specific interventions to managed resident #002's behaviors.

The licensee failed to ensure resident #002's written plan of care was setting out clear directions to staff to manage the inappropriate sexual behaviors. [s. 6. (1) (c)]

Issued on this 8th day of July, 2020

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

Original report signed by the inspector.