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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jul 13, 2016;	2016_333577_0010 (A1)	005711-16	Follow up

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

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

DEBBIE WARPULA (577) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension given from August 31, 2016 to September 30, 2016.

Issued on this 13 day of July 2016 (A1)

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

Original report signed by the inspector.

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

DEBBIE WARPULA (577) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 17, 18, 19 and 20, 2016.

This inspection was completed in order to follow-up on six compliance orders. Four orders were issued on February 25, 2016 with a compliance date of March 31, 2016. Two orders were issued on March 7, 2016, with a compliance date of April 29, 2016.

The four compliance orders were related to staff training on home's revised abuse policy, 24-hour admission care plans and staff training, proper application of restraints and consent for restraints.

The two compliance orders were related to plan of care, staff training on isolation precautions, identifying residents at high risk for dehydration and an audit of records, staff training on resident's plan of care and revisions, and staff training regarding continguency plans; staff training on transfer equipment and a transfer sling audit.

This inspection was conducted concurrently with Complaint inspection #2016_333577_0011.

During the course of this inspection, the inspectors(s) toured the resident care areas, observed the provision of care and services to residents, observed interactions between staff

and residents, reviewed policies, procedures and programs, various health care records, schedules and training records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Managers, Resident Assessment Instrument (RAI) Coordinator, Manager of Regional Behavioral Health Services, Environmental Services Manager (ESM), Registered Dietitians (RD), the Infection Control Lead (ICL), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Occupational Therapist (OT), Physiotherapists (PT), the Clinical Educator, the Manager of Motion Specialties, residents and family members.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

Training and Orientation

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

- **5 WN(s)**
- **0 VPC(s)**
- **6 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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).

Findings/Faits saillants :

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

a) Compliance Order #001 was issued during Inspection #2016_264609_006 with a compliance date of April 29, 2016. The home was ordered to ensure training and

retraining of all staff on the home's policies and procedures concerning isolation precautions. This order was related to a resident that was placed under a restriction for five days in January 2016, where isolation was not required and was not ordered.

The home did not complete the training and retraining of all direct care staff members on the home's policies and procedures related to isolation precautions.

On May 17, 2016, Inspector #577 requested training records from the Administrator to confirm that all staff had received training. The Inspector received a printed Medworxx online training report for hand hygiene and routine practices. The annual training report was gathered from April 1, 2015-March 31, 2016. Inspector #577 also received modules in a folder from each home area, titled "Infection Prevention & Control – Self Education", which included information on the following:

-handwash and handrub instructions with pictures and diagrams;
-personal protective equipment (PPE);
-a risk assessment algorithm;
-tub cleaning;
-bedpan flusher disinfecting, and
-basin washing.

Each module contained a staff signage sheet, with dates from April 28-May 16, 2016.

During an interview with the Infection Control Lead (ICL) #103, they reported that they developed the self-education modules for each home unit and that the modules did not contain details specific for isolation precautions. They further confirmed that not all staff had been trained.

The home's policy titled "Routine Practices and Additional Precautions – IC 1 15" last revised October 2013, defined the following precautions:

-routine practices;
-additional precautions;
-contact precautions;
-droplet precautions, and
-airborne precautions.

During an interview with the Administrator, they were not able to identify that the documents provided to the Inspector met the criteria for isolation precautions training. The home did not complete the training and retraining of all staff related to the home's policies and procedures for isolation precautions as previously ordered.

b) The home was ordered to identify all residents of the home who were at high risk of dehydration and audit each resident's fluid record.

Inspector's #621 and #577 requested documents of all residents of the home identified at risk of dehydration and an audit of their fluid records.

The Administrator provided Inspector #621 with a copy of a Heat Assessment which identified residents at risk for heat intolerance. The home did not provide evidence that they had identified all residents who were at high risk of dehydration or evidence that an audit of each resident's fluid record to ensure adequate fluid intake was conducted.

The Administrator reported that the home needed to do more work in this area.

c) The home was ordered to ensure training and retraining of all direct care staff of the home to ensure that they provided care as specified in each resident's plan of care and that any revisions to the plan of care were communicated to the appropriate members, especially related to nursing care measures.

Inspector #621 requested training records related to plan of care.

The Administrator provided Inspector #621 with a copy of the RPN – Resident Focused Shift Report and an attendance sheet dated between April 18, 2016, and May 17, 2016.

During an interview with the Administrator on May 20, 2016, they reported that a process was started to have staff review a care plan by 1400 hours (hrs) each day, but that this work was ongoing and that they were unable to provide evidence that all staff were trained/retrained or information on what the training entailed.

d) The home was ordered to ensure training and retraining of all direct care staff related to the home's policies, procedures and contingency plans when working with less staff than the regular deployment, especially related to filling vacant shifts

and redeployment of staff to meet the needs of the residents of the home.

During an interview with the Administrator on May 20, 2016, the Administrator reported to Inspectors #621 and #577 that the management speaks with registered nursing staff about the home's expectations around staffing and how to deploy staff. They confirmed that they did not maintain a record of the training provided, details as to what the training entailed, and identified that not all direct care staff had been trained. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During observations of resident #001 for three days in May 2016, Inspector #577 found a loose apparatus and a second loose device. The Inspector confirmed placement of the second apparatus with PSW #105, Occupational Therapist (OT) #106 and Clinical Manager #104.

During a record review of the resident's health care records, Inspector #577 could not find any indication for the second device in the care plan document, although an apparatus was documented in the care plan document.

During an interview with RPN #120, they confirmed that the care plan did not contain information regarding the second device.

During an interview with Clinical Manager #104 they confirmed that the resident did not have the second device in their care plan. [s. 6. (7)]

3. During observations of resident #002 on two days in May 2016, Inspector #577 found the resident seated in a special chair an apparatus in place.

During a review of resident #002's current care plan document, the Inspector found the intervention which indicated another type of apparatus.

Inspector #577 confirmed placement of the second apparatus with OT #106 who identified it as a positioning apparatus.

Physiotherapist (PT) #107 and PT #116 both reported that the correct placement should be secured around the resident's waist.

During a record review of the home's policy titled "Least Restraint Program - LTC 3-100", last revised May 2013, it indicated the following:

-the registered staff reviews and revises the plan of care related to restraints and PASDs;

-the PSW never applies a restraint without the assessment and approval of the registered staff, and

-the PSW follows the care plan.

During an interview with Clinical Manager #104, they confirmed that resident #002 did not have information documented for the second apparatus in their care plan. [s. 6. (7)]

4. A complaint was received by the Director in May 2016, which identified an incident that occurred in May 2016, where resident #005 was found behind the nursing desk attempting to ingest a certain substance.

A review of the internal incident report identified that the resident was found beside the nursing desk attempting to ingest a certain substance that was non-toxic and staff attended to the resident.

A review of the care plan for resident #005 in place prior to the incident indicated an expected outcome that the resident would not ingest certain substances and there were nursing interventions in place for the resident.

During an interview with the Manager of Regional Behavioral Health Services #108, they reported that the resident had ingested a certain substance which was non-toxic and the staff attended to the resident. [s. 6. (7)]

5. A complaint was received by the Director in May 2016, which alleged that resident #007 had numerous falls since their admission.

During a record review of resident #007's progress notes, Inspector #577 found that the resident had many falls since admission.

Upon further review of resident's progress notes, the Inspector found that following one of the falls, the bed safety interventions were not in place, as per their care

plan.

During a record review of the home's policy titled "Fall Prevention and Management Program – LTC 3-60" last revised April 2014, it indicated that the PSW follows the care plan and provides input for possible fall prevention strategies. [s. 6. (7)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect was complied with.

Compliance order #004 was issued during Inspection #2015_435621_0012 with a compliance date of March 31, 2016. The home was ordered to ensure that all staff were trained on the home's revised policy titled "Zero Tolerance of Abuse and Neglect of Residents - LTC 5-50" last updated January 2015.

During a record review of the home's Medworxx training on the revised policy titled "Zero Tolerance of Abuse and Neglect" identified that a total of 372/489 staff, or 76 per cent of staff were trained up to March 31, 2016.

During an interview with the Administrator on May 20, 2016, they reported to Inspectors #577 and #621 that while required revisions to the definition of verbal abuse were made to the home's policy titled "Zero Tolerance of Abuse and Neglect - LTC 5-50" last updated January 2015, not all staff had been trained on the revised policy. [s. 20. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident.
O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 24-hour admission care plan sets out clear directions to staff and others who provide direct care to the resident.

Compliance Order #001 was issued during Inspection #2016_246196_0002 with a compliance date of March 31, 2016. The home was ordered to ensure that the 24-hour admission care plan set out clear directions to staff and information about restraint use was clearly indicated on those plans and staff were to receive training.

a) During a record review of resident #004's 24-hour admission plan of care dated in May 2016, Inspector #621 found a special apparatus use documented.

During an interview with RN #109, they reported to the inspector that the resident did not require any apparatus since their admission.

RN #109 reviewed the 24-hour admission plan of care for resident #004 and identified that a section of the care plan had been checked off incorrectly, and that the notation for an apparatus was written in error, and should have not been identified on the 24-hour plan of care as a measure.

b) Inspector #621 reviewed resident #005's 24-hour admission plan of care dated May 9, 2016, which indicated apparatus use.

During an interview with PSW #110 they reported to the inspector that the resident did not require an apparatus.

RN #117 reviewed the 24-hour admission plan of care for this resident dated in May 2016, and confirmed with the inspector that the information in the care plan was incorrect.

During an interview with the Administrator they reported to Inspector #621 and #577 that training was a work in progress and provided Inspectors with copies of an RPN – resident focused shift report as evidence of training on 24-hour admission care plans. No evidence was provided that training on the 24-hour admission care plan was completed. [s. 24. (3)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

WN #4: 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 failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

a) Compliance Order #002 was issued during Inspection #2016_264609_006 with a compliance date of April 29, 2016. The home was ordered to ensure that all direct care staff received training and retraining specific to procedures and policies when there was not sufficient transfer equipment available.

Inspector #577 requested training records from the Administrator to confirm that all staff had received training.

The home did not provide evidence to support that training and retraining was provided to all direct care staff on the home's policies and procedures when there was not sufficient equipment available to meet the needs of residents, especially related to transfer equipment.

The Administrator provided Inspector #577 with photocopies titled "Repositioning

Aid Blitz" with 76 staff signatures, dated April 12, 14, 21, 26 and 29, 2016. The home did not provide evidence to support that training and retraining was provided to all direct care staff and did not maintain a record of what "Repositioning Aid Blitz" entailed.

During an interview with the Administrator they reported that they refer staff to the minimal lift policy and that not all staff were trained.

b) Compliance Order #002 was issued during Inspection #2016_264609_006 with a compliance date of April 29, 2016. The home was ordered to perform an audit of every resident of the home and identify which residents required transfer devices. The home was also ordered to ensure that each resident identified in the audit had a transfer device available and to maintain records of the audit, including when it was completed, by whom and what actions occurred as result of audit.

Inspector #577 requested an audit that identified residents who required transfer devices and evidence that those residents received a transfer device.

The Administrator provided Inspector #577 with the home's audit of residents and those who required transfer devices. Inspector #577 reviewed the home's audit of and found photocopied staff/resident worksheets dated May 2-4, 2016. The resident worksheets did not include confirmation that each resident identified in the audit had a transfer device available; who completed the audit and what actions occurred as result of audit. Additionally, Inspector received a document titled "Inventory of need" dated February 25, 2016, which indicated a tally of 121 transfer devices, divided between the different home units.

c) Compliance Order #002 was issued during Inspection #2016_264609_006 with a compliance date of April 29, 2016. The home was ordered to ensure training and retraining to all direct care and laundry staff on home's policies and procedures when transfer devices or other equipment become soiled and how to have the equipment replaced promptly.

Inspector #577 requested training records from the Administrator to confirm that all required staff had received training.

The Administrator provided Inspector #577 with photocopies titled "Repositioning Aid Blitz" with 76 staff signatures, dated April 12, 14, 21, 26 and 29, 2016. The home did not provide evidence to support that training and retraining was provided

to all direct care staff and laundry staff and did not maintain a record of what the "Repositioning Aid Blitz" entailed. [s. 44.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 004

WN #5: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met when a resident was being restrained by a physical device under section 31 of the Act: That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

Compliance Order #002 was issued during Inspection #2016_246196_0002 with a compliance date of March 31, 2016. The home was ordered to ensure that staff only apply a special apparatus in accordance with any instructions specified by the physician or registered nurse in the extended class. If there are no instructions, the home was to ensure that apparatus were applied according to Best Practice Guidelines.

On a day in May 2016, resident #001 was observed seated in a special chair with a loose fitting rear facing apparatus and a second loose fitting apparatus. Inspector

#577 was able to place two closed fists between the apparatus and the chair. The second apparatus was able to move down to the resident's knees. The resident could not unfasten the second apparatus. PSW #111 confirmed incorrect placement of the resident's apparatus and they were unable to secure the apparatus.

On a day in May 2016, Inspector #577 observed resident #001 seated in a special chair with their apparatus positioned incorrectly. RPN #120 confirmed incorrect placement of residents apparatus and secured it correctly.

On another day in May 2016, Inspector #577 observed resident #001 seated in a special chair with their apparatus positioned incorrectly. The OT #106 confirmed incorrect placement of the apparatus. A few minutes later, the Inspector observed the apparatus to be positioned higher on the resident. Inspector alerted RN #112 to the incorrect placement and the RN #112 stated they weren't certain how it should be placed and walked down the hallway away from the resident and the Inspector. At that time, the Inspector alerted Clinical Manager #104 to the incorrect placement of the apparatus, they confirmed incorrect placement and readjusted it.

During a record review of resident #001's current care plan and kardex, the Inspector found the following interventions indicating an apparatus.

During an interview with RPN #120 they confirmed that a second device was not documented in the resident's care plan.

The home's policy titled "Least Restraint Program - LTC 3-100" last revised May 2013, indicated:

-registered staff were to supervise the application of certain apparatus according to the order and manufacturer's instructions;

-registered staff were to direct the PSWs to monitor the resident hourly and to release and reposition the resident every two hours.

During an interview with Clinical Manager #104 on May 20, 2016, they reported that resident #001 did not have their rear facing aparatus positioned correctly and their second apparatus wasn't documented in the care plan. They further confirmed that it was the expectation of the home that resident's apparatus' are applied correctly and documented clearly in the care plan. [s. 110. (2) 2.]

2. A review of the health care records for resident #002 determined a physician's order for an apparatus when in their chair.

During observations of resident #002 on two days in May 2016, Inspector #577 found the resident seated in a chair with an apparatus applied. The Inspector determined that the resident could not unfasten it.

During a review of resident #002's current care plan, the Inspector found the intervention which indicated front closing apparatus.

The home's policy titled "Least Restraint Program - LTC 3-100", last revised May 2013, indicated:

-registered staff would obtain a physician's order or Nurse Practitioner's order for the type and reason for the apparatus, and

-registered staff supervises the application of the apparatus according to the order and
manufacturer's instructions.

During an interview with OT #106, they reported that resident #002 was wearing a positioning apparatus.

During an interview with PSW #113 and PSW #114, both reported that they were unclear about the correct placement of the resident's apparatus.

During an interview with PT #107 and PT #116, both reported that the apparatus was not properly aligned and should have been secured to a different area.

During an interview with the Clinical Educator #124, they reported that staff were trained about apparatus use and that they have not seen any manufacturer's instructions for apparatus application for staff.

During an interview with the Clinical Manager #104, they confirmed that the apparatus wasn't documented in the care plan. They further confirmed that it was the expectation of the home that resident's apparatus are applied correctly and documented clearly in the care plan. [s. 110. (2) 2.]

3. During a review of resident #007's care plan that was in place for February-May 2016, Inspector #577 found the intervention which indicated that the resident used a special chair with an apparatus on a daily basis.

During a record review of the progress notes for resident #007, the inspector found a notation made by the physician in March 2016, which indicated that they ordered an apparatus to be applied.

A further review of resident #007's progress notes, Inspector #577 found incorrect application of the resident's apparatus which resulted in five falls.

On a certain day in 2016, the resident had a witnessed fall in the hallway and had hit their head on the door frame in their room. They got out of their wheelchair while the belt of the wheelchair was still secured. The resident continuously tried to get out of his wheelchair by sliding underneath the belt;

On a certain day in 2016, the resident required a boost in their chair as they were almost falling out of the chair. The resident was pushing the seatbelt up and trying to slide beneath it out of the chair. The seatbelt was as high as the resident's breast line. The seatbelt was not secured to the chair and was moveable;

The home's policy titled "Least Restraint Program LTC 3-100" last revised May 2013, indicated:

-registered staff were to supervise the application of the apparatus according to the order and manufacturer's instructions, and

-registered staff were to direct the PSWs to monitor the resident hourly, and to release and reposition the resident every two hours. [s. 110. (2) 2.]

4. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: The person who made the order, what device was ordered, and any instructions relating to the order.

On May 20, 2016, Inspector #621 reviewed resident #006's admission 24 hour plan of care dated May 2, 2016, which indicated that the resident required a special device due to a specific behaviour. However, on review of the health care record,

there was no physician's order for this device identified in the resident's documentation.

During an interview with RN #117 and RPN #118 on May 20, 2016, they reported to Inspector #621 that this resident wore a special device due to issues of exit seeking. RPN #118 reported that they observed this resident wearing the device on two days in May 2016, while on duty.

During an interview with RN #117, they reported to the Inspector that the documentation required before applying a special device to a resident included a physician's order on the resident's chart for aplication.

RN #117 confirmed with Inspector #621 that the resident did not have a physician's order for a special device to be applied and should have. [s. 110. (7) 3.]

5. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: Consent.

During observations of resident #001 on three days in May 2016, Inspector #577 found resident seated in a special chair with an apparatus and a device. This was confirmed by OT #106, PSW #111 and RPN #120.

During a record review, Inspector found a Substitute Decision Maker (SDM) consent for an apparatus dated January 23, 2016. The consent from the SDM for the use of an apparatus did not include the second device.

During an interview with Clinical Manager #104, they confirmed that resident #001 did not have SDM consent for the second device and that it was the expectation of the home that staff obtain consent. [s. 110. (7) 4.]

6. A review of the health care records for resident #002 determined a physician's order for an apparatus when in a chair.

During observations of resident #002 on two days in May 2016, Inspector #577 noted the resident seated in a chair with a second device.

During a review of resident #002's current care plan, the Inspector found the

intervention which indicated front facing apparatus.

During a record review of resident's health care records, Inspector #577 could not find a consent from the Substitute Decision Maker (SDM) for a second device. Consent was only given for the apparatus.

The home's policy titled "Least Restraint Program - LTC 3-100", last revised May 2013, indicated that staff would ensure that the resident/SDM has provided informed consent.

During an interview with the Clinical Manager #104, they confirmed that an SDM consent was not obtained for the resident's second device and consent should be always obtained from the SDM. [s. 110. (7) 4.]

7. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that consent was documented.

Compliance Order #003 was issued during Inspection #2016_246196_0002 with a compliance date of March 31, 2016. The home was ordered to ensure that there was documented consent for restraint use.

In May 2016, Inspector #621 reviewed resident #006's admission 24-hour plan of care dated May 2, 2016, which indicated that the resident required a special device due to a specific behaviour. However, on review of the health care record, the consent form dated May 2, 2016, identified that no devices were required at that time.

During an interview with RN #117 and RPN #118 on May 20, 2016, they reported to Inspector #621 that the resident wore a special device due to specific behaviours. RPN #118 reported that they observed the resident wearing the device for two days in May 2016.

During an interview with RN #117, they reported to the Inspector that the documentation required before applying a special device to a resident included consent from the Substitute Decision Maker (SDM) and completion of a form.

RN #117 confirmed with Inspector #621 that the resident did not have consent from

the SDM for a special device to be applied, and should have. [s. 110. (7) 4.]

Additional Required Actions:

CO # - 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 005,006

Issued on this 13 day of July 2016 (A1)

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

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DEBBIE WARPULA (577) - (A1)

Inspection No. / No de l'inspection : 2016_333577_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 005711-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Jul 13, 2016;(A1)

Licensee / Titulaire de permis :
ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251,
THUNDER BAY, ON, P7B-5G7

LTC Home / Foyer de SLD :
HOGARTH RIVERVIEW MANOR
300 LILLIE STREET, THUNDER BAY, ON,
P7C-4Y7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Meaghan Sharp

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 ST. JOSEPH'S CARE GROUP, 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: 2016_264609_0006, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall:

a) Provide retraining to all staff involved in caring for residents on the home’s policies and procedures related to isolation precautions. This retraining will be specific to additional precautions, contact precautions, droplet precautions, and airborne precautions. The home will maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed.

b) Identify all residents of the home who are at risk of dehydration.

c) Complete a fluid record audit of those resident's identified, to ensure adequate fluid intake is provided and correctly documented in the resident clinical records.

d) Put into place a system to conduct routinely scheduled audits of residents' plans of care to ensure they are providing care as specified in each residents’ plan of care. The audit sample shall ensure representation of residents from a variety of home areas and include residents requiring interventions related to falls prevention and management, restraints and responsive behaviours. The audits are to be conducted by registered staff or a member of the home's leadership team. Each audit must be reviewed by a member of the home's leadership team to verify accuracy of the audit, to document actions taken to address specific deficient findings and to document system level changes made in response to the findings.

e) Provide retraining to all direct care staff of the home on resident’s plan of care and revisions to the plan of care, especially related to nursing care measures. The home will maintain a record of retraining, what the training entailed, who completed the training and when the training was completed.

f) Provide retraining to all direct care staff related to the home’s policies, procedures and contingency plans when working with less staff than the regular deployment especially related to filling vacant shifts and redeployment of staff. The home will maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed.

Grounds / Motifs :

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

a) Compliance Order #001 was issued during Inspection #2016_264609_006 with a compliance date of April 29, 2016. The home was ordered to ensure training and retraining of all staff on the home's policies and procedures concerning isolation precautions. This order was related to a resident that was placed in isolation for five days in January 2016, where isolation was not required and was not ordered.

The home did not complete the training and retraining of all direct care staff members on the home's policies and procedures related to isolation precautions.

On May 17, 2016, Inspector #577 requested training records from the Administrator to confirm that all staff had received training. The Inspector received a printed Medworxx online training report for hand hygiene and routine practices. The annual training report was gathered from April 1, 2015-March 31, 2016. Inspector #577 also received modules in a folder from each home area, titled "Infection Prevention & Control – Self Education", which included information on the following:

-handwash and handrub instructions with pictures and diagrams;
-personal protective equipment (PPE);
-a risk assessment algorithm;
-tub cleaning;
-bedpan flusher disinfecting, and
-basin washing.

Each module contained a staff signage sheet, with dates from April 28-May 16, 2016.

During an interview with the Infection Control Lead (ICL) #103, they reported that they developed the self-education modules for each home unit and that the modules did not contain details specific for isolation precautions. They further confirmed that not all staff had been trained.

The home's policy titled "Routine Practices and Additional Precautions – IC 1 15" last

revised October 2013, defined the following precautions:

-routine practices;
-additional precautions;
-contact precautions;
-droplet precautions, and
-airborne precautions.

During an interview with the Administrator, they were not able to identify that the documents provided to the Inspector met the criteria for isolation precautions training. The home did not complete the training and retraining of all staff related to the home's policies and procedures for isolation precautions as previously ordered.

b) The home was ordered to identify all residents of the home who were at high risk of dehydration and audit each resident's fluid record.

Inspector's #621 and #577 requested documents of all residents of the home identified at risk of dehydration and an audit of their fluid records.

The Administrator provided Inspector #621 with a copy of a Heat Assessment which identified residents at risk for heat intolerance. The home did not provide evidence that they had identified all residents who were at high risk of dehydration or evidence that an audit of each resident's fluid record to ensure adequate fluid intake was conducted.

The Administrator reported that the home needed to do more work in this area.

c) The home was ordered to ensure training and retraining of all direct care staff of the home to ensure that they provided care as specified in each resident's plan of care and that any revisions to the plan of care were communicated to the appropriate members, especially related to nursing care measures.

Inspector #621 requested training records related to plan of care.

The Administrator provided Inspector #621 with a copy of the RPN – Resident Focused Shift Report and an attendance sheet dated between April 18, 2016, and May 17, 2016.

During an interview with the Administrator on May 20, 2016, they reported that a process was started to have staff review a care plan by 1400 hours (hrs) each day, but that this work was ongoing and that they were unable to provide evidence that all staff were trained/retrained or information on what the training entailed.

d) The home was ordered to ensure training and retraining of all direct care staff related to the home's policies, procedures and contingency plans when working with less staff than the regular deployment, especially related to filling vacant shifts and redeployment of staff to meet the needs of the residents of the home.

During an interview with the Administrator on May 20, 2016, the Administrator reported to Inspectors #621 and #577 that the management speaks with registered nursing staff about the home's expectations around staffing and how to deploy staff. They confirmed that they did not maintain a record of the training provided, details as to what the training entailed, and identified that not all direct care staff had been trained. (577)

2. During observations of resident #002 on two days in May 2016, Inspector #577 found the resident seated in a special chair with an apparatus in place.

During a review of resident #002's current care plan document, the Inspector found the intervention which indicated another type of apparatus.

Inspector #577 confirmed placement of the second apparatus with OT #106 who identified it as a positioning belt.

Physiotherapist (PT) #107 and PT #116 both reported that the correct placement should be secured around the resident's waist.

During a record review of the home's policy titled "Least Restraint Program - LTC 3-100", last revised May 2013, it indicated the following:

-the registered staff reviews and revises the plan of care related to restraints and PASDs;

-the PSW never applies a restraint without the assessment and approval of the registered staff, and

-the PSW follows the care plan.

During an interview with Clinical Manager #104, they confirmed that resident #002 did not have information documented for a thigh restraint in their care plan.

Non-compliance was previously identified under inspection 2016_264609_0006, including a compliance order served March 7, 2016.

The decision to re-issue this compliance order was based on the scope of this issue which was identified as a pattern, the severity which indicated actual harm/risk and the compliance history which in spite of a previous compliance order has continued to be non compliant with this area of the legislation.
(577)

3. During observations of resident #002 on two days in May 2016, Inspector #577 found the resident seated in a special chair with an apparatus in place.

During a review of resident #002's current care plan document, the Inspector found the intervention which indicated another type of apparatus.

Inspector #577 confirmed placement of the second apparatus with OT #106 who identified it as a positioning belt.

Physiotherapist (PT) #107 and PT #116 both reported that the correct placement should be secured around the resident's waist.

During a record review of the home's policy titled "Least Restraint Program - LTC 3-100", last revised May 2013, it indicated the following:

-the registered staff reviews and revises the plan of care related to restraints and PASDs;

-the PSW never applies a restraint without the assessment and approval of the registered staff, and

-the PSW follows the care plan.

During an interview with Clinical Manager #104, they confirmed that resident #002 did not have information documented for a thigh restraint in their care plan.

Non-compliance was previously identified under inspection 2016_264609_0006, including a compliance order served March 7, 2016.

The decision to re-issue this compliance order was based on the scope of this issue which was identified as a pattern, the severity which indicated actual harm/risk and the compliance history which in spite of a previous compliance order has continued to be non compliant with this area of the legislation.
(577)

4. A complaint was received by the Director in May 2016, which alleged that resident #007 had numerous falls since their admission.

During a record review of resident #007's progress notes, Inspector #577 found that the resident had many falls since admission.

Upon further review of resident's progress notes, the Inspector found that following one of the falls, the bed safety interventions were not in place, as per their care plan.

During a record review of the home's policy titled "Fall Prevention and Management Program – LTC 3-60" last revised April 2014, it indicated that the PSW follows the care plan and provides input for possible fall prevention strategies. (577)

5. A complaint was received by the Director in May 2016, which alleged that resident #007 had numerous falls since their admission.

During a record review of resident #007's progress notes, Inspector #577 found that the resident had many falls since admission.

Upon further review of resident's progress notes, the Inspector found that following one of the falls, the bed safety interventions were not in place, as per their care plan.

During a record review of the home's policy titled "Fall Prevention and Management Program – LTC 3-60" last revised April 2014, it indicated that the PSW follows the care plan and provides input for possible fall prevention strategies. (621)

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

Sep 30, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_435621_0012, CO #004;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Provide retraining to all direct care staff on the home's revised policy titled "Zero tolerance of Abuse and Neglect of Residents" and ensure that the policy is complied with. The home will maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect was complied with.

Compliance order #004 was issued during Inspection #2015_435621_0012 with a compliance date of March 31, 2016. The home was ordered to ensure that all staff were trained on the home's revised policy titled "Zero Tolerance of Abuse and Neglect of Residents - LTC 5-50" last updated January 2015.

During a record review of the home's Medworxx training on the revised policy titled "Zero Tolerance of Abuse and Neglect" identified that a total of 372/489 staff, or 76 per cent of staff were trained up to March 31, 2016.

During an interview with the Administrator on May 20, 2016, they reported to Inspectors #577 and #621 that while required revisions to the definition of verbal abuse were made to the home's policy titled "Zero Tolerance of Abuse and Neglect - LTC 5-50" last updated January 2015, not all staff had been trained on the revised policy. [s. 20. (1)]

Non-compliance was previously identified under inspection 2015_435621_0012 (A1), including a compliance order served February 25, 2016.

The decision to re-issue this compliance order was based on the scope of this issue which was identified as a pattern of home's non-compliance with their training of the home's policy promoting zero tolerance of abuse and neglect; the severity which indicated minimal harm or potential for actual harm and the compliance history which in spite of a previous compliance order has continued to be non compliant with this area of the legislation.
(621)

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

Sep 30, 2016(A1)

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2016_246196_0002, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and
(b) clear directions to staff and others who provide direct care to the resident.
O. Reg. 79/10, s. 24 (3).

Order / Ordre :

The licensee shall:

a) Put into place a system to conduct routinely scheduled audits of 24-hour admission care plans to ensure they are providing clear direction in each residents' plan of care and subsequent plans of care. The audit sample shall ensure representation of residents from a variety of home areas and include residents requiring interventions related to restraints. The audits are to be conducted by registered staff or a member of the home's leadership team. Each audit must be reviewed by a member of the home's leadership team to verify accuracy of the audit, to document actions taken to address specific deficient findings and to document system level changes made in response to the findings.

b) Provide retraining to all direct care staff of the home on 24-hour admission care plans, especially related to nursing care measures. The home will maintain a record of retraining, what the training entailed, who completed the training and when the training was completed.

Grounds / Motifs :

1. The licensee has failed to ensure that the 24-hour admission care plan sets out clear directions to staff and others who provide direct care to the resident.

Compliance Order #001 was issued during Inspection #2016_246196_0002 with a compliance date of March 31, 2016. The home was ordered to ensure that the 24-hour admission care plan set out clear directions to staff and information about restraint use was clearly indicated on those plans and staff were to receive training.

a) During a record review of resident #004's 24-hour admission plan of care dated in May 2016, Inspector #621 found a special apparatus use documented.

During an interview with RN #109, they reported to the inspector that the resident did not require any apparatus since their admission.

RN #109 reviewed the 24-hour admission plan of care for resident #004 and identified that a section of the care plan had been checked off incorrectly, and that the notation for an apparatus was written in error, and should have not been identified on the 24-hour plan of care as a measure.

b) Inspector #621 reviewed resident #005's 24-hour admission plan of care dated May 9, 2016, which indicated apparatus use.

During an interview with PSW #110 they reported to the inspector that the resident did not require an apparatus.

RN #117 reviewed the 24-hour admission plan of care for this resident dated in May 2016, and confirmed with the inspector that the information in the care plan was incorrect.

During an interview with the Administrator they reported to Inspector #621 and #577 that training was a work in progress and provided Inspectors with copies of an RPN – resident focused shift report as evidence of training on 24-hour admission care plans. No evidence was provided that training on the 24-hour admission care plan was completed. [s. 24. (3)]

Non-compliance was previously identified under inspection 2016_246196_0002 (A1), including a compliance order served February 25, 2016.

The decision to re-issue this compliance order was based on the scope of this issue which was identified as a pattern, the severity which indicated minimal harm or potential for actual harm and the compliance history which in spite of a previous compliance order has continued to be non compliant with this area of the legislation. (621)

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

Sep 30, 2016(A1)

Order # /
Ordre no : 004

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

Linked to Existing Order /
Lien vers ordre existant: 2016_264609_0006, CO #002;

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall:

a) Provide retraining to all direct care staff on the home's procedures and policies when there is not sufficient transfer equipment available to meet the needs of residents. The home will maintain a record of retraining, what the training entailed, who completed the training and when the training was completed.

b) Provide retraining to all direct care and laundry staff on the home's procedures and policies when transfer equipment or other equipment become soiled and how to replace the equipment promptly. The home will maintain a record of retraining, what the training entailed, who completed the training and when the training was completed.

c) Provide an audit of every resident of the home and identify which residents have a dedicated, properly sized transfer sling. This audit will identify when it was completed, by who and what actions occurred as a result of the audit.

Grounds / Motifs :

1. 1. The licensee failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

a) Compliance Order #002 was issued during Inspection #2016_264609_006 with a compliance date of April 29, 2016. The home was ordered to ensure that all direct care staff received training and retraining specific to procedures and policies when there was not sufficient transfer equipment available.

Inspector #577 requested training records from the Administrator to confirm that all staff had received training.

The home did not provide evidence to support that training and retraining was provided to all direct care staff on the home's policies and procedures when there was not sufficient equipment available to meet the needs of residents, especially related to transfer equipment.

The Administrator provided Inspector #577 with photocopies titled "Repositioning Aid Blitz" with 76 staff signatures, dated April 12, 14, 21, 26 and 29, 2016. The home did

not provide evidence to support that training and retraining was provided to all direct care staff and did not maintain a record of what "Repositioning Aid Blitz" entailed.

During an interview with the Administrator they reported that they refer staff to the minimal lift policy and that not all staff were trained.

b) Compliance Order #002 was issued during Inspection #2016_264609_006 with a compliance date of April 29, 2016. The home was ordered to perform an audit of every resident of the home and identify which residents required transfer devices. The home was also ordered to ensure that each resident identified in the audit had a transfer device available and to maintain records of the audit, including when it was completed, by whom and what actions occurred as result of audit.

Inspector #577 requested an audit that identified residents who required transfer devices and evidence that those residents received a transfer device.

The Administrator provided Inspector #577 with the home's audit of residents and those who required transfer devices. Inspector #577 reviewed the home's audit of and found photocopied staff/resident worksheets dated May 2-4, 2016. The resident worksheets did not include confirmation that each resident identified in the audit had a transfer device available; who completed the audit and what actions occurred as result of audit. Additionally, Inspector received a document titled "Inventory of need" dated February 25, 2016, which indicated a tally of 121 transfer devices, divided between the different home units.

c) Compliance Order #002 was issued during Inspection #2016_264609_006 with a compliance date of April 29, 2016. The home was ordered to ensure training and retraining to all direct care and laundry staff on home's policies and procedures when transfer devices or other equipment become soiled and how to have the equipment replaced promptly.

Inspector #577 requested training records from the Administrator to confirm that all required staff had received training.

The Administrator provided Inspector #577 with photocopies titled "Repositioning Aid Blitz" with 76 staff signatures, dated April 12, 14, 21, 26 and 29, 2016. The home did not provide evidence to support that training and retraining was provided to all direct care staff and laundry staff and did not maintain a record of what the "Repositioning

Aid Blitz" entailed. [s. 44.]

Non-compliance was previously identified under inspection 2016_264609_0006, including a compliance order served March 7, 2016.

The decision to re-issue this compliance order was based on the scope of this issue which was identified as a pattern, the severity which indicated minimal harm or potential for actual harm and the compliance history which in spite of a previous compliance order has continued to be non compliant with this area of the legislation. (577)

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

Sep 30, 2016(A1)

Order # /
Ordre no : 005

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

Linked to Existing Order /
Lien vers ordre existant: 2016_246196_0002, CO #002;

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 shall:

a) Conduct an audit, to be completed by a registered professional with training and current knowledge of restraints and restraint application, for all restraints used in the home;

b) Record the data collected in the audit including, but not limited to, residents' names, the type of restraints in use, the criteria for use of the restraints (i.e. when in wheelchair,etc.) and the initial assessments of the application of each restraint (i.e. applied correctly, applied incorrectly, in good condition, requires replacement, etc.);

c) Mitigate any risk and address immediate concerns identified during the audit related to the application of each restraint including, but not limited to, loose or improper application positioning;

d) Ensure all required orders, consents, care plans and any other required documentation related to the applications and use of the restraints are accurate, current and complete for each device;

e) Following the initial audit and preliminary assessment by a registered professional with training and current knowledge of restraints and restraint applications, refer any outstanding restraint concerns to an Occupational Therapist (OT) to be further assessed and addressed; and

f) Provide training to all direct care staff and registered staff in correct application and positioning of restraints, monitoring requirements, repositioning requirements, reapplication requirements, the identification of immediate restraint risk, the expected response to witnessing immediate risk to residents, and the expectation of direct care staff and registered staff related to documentation. The home will maintain a record of the training, what the training entailed, who completed the training and when the training was completed.

g) Provide visual illustration of proper restraint application to all direct care staff and registered staff.

Grounds / Motifs :

1. During a review of resident #007's care plan that was in place for February-May 2016, Inspector #577 found the intervention which indicated that the resident used a special chair with an apparatus on a daily basis.

During a record review of the progress notes for resident #007, the inspector found a notation made by the physician in March 2016, which indicated that they ordered an apparatus to be applied.

A further review of resident #007's progress notes, Inspector #577 found incorrect application of the resident's apparatus which resulted in five falls.

On a certain day in 2016, the resident had a witnessed fall in the hallway and had hit their head on the door frame in their room. They got out of their wheelchair while the belt of the wheelchair was still secured. The resident continuously tried to get out of his wheelchair by sliding underneath the belt;

On a certain day in 2016, the resident required a boost in their chair as they were almost falling out of the chair. The resident was pushing the seatbelt up and trying to slide beneath it out of the chair. The seatbelt was as high as the resident's breast line. The seatbelt was not secured to the chair and was moveable;

The home's policy titled "Least Restraint Program LTC 3-100" last revised May 2013, indicated:

-registered staff were to supervise the application of the apparatus according to the order and manufacturer's instructions, and

-registered staff were to direct the PSWs to monitor the resident hourly, and to release and reposition the resident every two hours. [s. 110. (2) 2.]

(577)

2. During a review of resident #007's care plan that was in place for February-May 2016, Inspector #577 found the intervention which indicated that the resident used a special chair with an apparatus on a daily basis.

During a record review of the progress notes for resident #007, the inspector found a notation made by the physician in March 2016, which indicated that they ordered an apparatus to be applied.

A further review of resident #007's progress notes, Inspector #577 found incorrect application of the resident's apparatus which resulted in five falls.

On a certain day in 2016, the resident had a witnessed fall in the hallway and had hit their head on the door frame in their room. They got out of their wheelchair while the belt of the wheelchair was still secured. The resident continuously tried to get out of his wheelchair by sliding underneath the belt;

On a certain day in 2016, the resident required a boost in their chair as they were almost falling out of the chair. The resident was pushing the seatbelt up and trying to slide beneath it out of the chair. The seatbelt was as high as the resident's breast line. The seatbelt was not secured to the chair and was moveable;

The home's policy titled "Least Restraint Program LTC 3-100" last revised May 2013, indicated:

-registered staff were to supervise the application of the apparatus according to the order and manufacturer's instructions, and

-registered staff were to direct the PSWs to monitor the resident hourly, and to release and reposition the resident every two hours. [s. 110. (2) 2.]

(577)

3. During a review of resident #007's care plan that was in place for February-May 2016, Inspector #577 found the intervention which indicated that the resident used a special chair with an apparatus on a daily basis.

During a record review of the progress notes for resident #007, the inspector found a notation made by the physician in March 2016, which indicated that they ordered an apparatus to be applied.

A further review of resident #007's progress notes, Inspector #577 found incorrect application of the resident's apparatus which resulted in five falls.

On a certain day in 2016, the resident had a witnessed fall in the hallway and had hit their head on the door frame in their room. They got out of their wheelchair while the belt of the wheelchair was still secured. The resident continuously tried to get out of his wheelchair by sliding underneath the belt;

On a certain day in 2016, the resident required a boost in their chair as they were almost falling out of the chair. The resident was pushing the seatbelt up and trying to slide beneath it out of the chair. The seatbelt was as high as the resident's breast line. The seatbelt was not secured to the chair and was moveable;

The home's policy titled "Least Restraint Program LTC 3-100" last revised May 2013, indicated:

-registered staff were to supervise the application of the apparatus according to the order and manufacturer's instructions, and

-registered staff were to direct the PSWs to monitor the resident hourly, and to release and reposition the resident every two hours. [s. 110. (2) 2.]

(577)

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

Sep 30, 2016(A1)

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2016_246196_0002, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee shall:

a) Ensure all consents and any other required documentation related to the applications and use of the restraints are accurate, current and complete for each device.

Grounds / Motifs :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that consent was documented.

Compliance Order #003 was issued during Inspection #2016_246196_0002 with a compliance date of March 31, 2016. The home was ordered to ensure that there was documented consent for restraint use.

On May 20, 2016, Inspector #621 reviewed resident #006's admission 24-hour plan of care dated May 2, 2016, which indicated that the resident required a special device due to a specific behaviour. However, on review of the health care record, the consent for Restraint or Personal Assistive Service Device (PASD) form dated May 2, 2016, identified that no restraint/PASD was required at that time.

During an interview with RN #117 and RPN #118 on May 20, 2016, they reported to Inspector #621 that the resident wore a special device due to a specific behaviour. RPN #118 reported that they observed the resident wearing the device on two days in May 2016, while on duty.

During an interview with RN #117, they reported to the Inspector that the documentation required before applying a special device to a resident included consent from the Substitute Decision Maker (SDM) and completion of the restraint section for a Personal Support Assistive Device (PASD) form.

RN #117 confirmed with Inspector #621 that the resident did not have consent from the SDM for a special device to be applied, and should have. (577)

2. 5. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: Consent.

During observations of resident #001 on three days in May 2016, Inspector #577 found resident seated in a special chair with an apparatus and a device. This was confirmed by OT #106, PSW #111 and RPN #120.

During a record review, Inspector found a Substitute Decision Maker (SDM) consent for an apparatus dated January 23, 2016. The consent from the SDM for the use of an apparatus did not include the second device.

During an interview with Clinical Manager #104, they confirmed that resident #001 did not have SDM consent for the second device and that it was the expectation of the home that staff obtain consent. [s. 110. (7) 4.]

6. A review of the health care records for resident #002 determined a physician's order for an apparatus when in a chair.

During observations of resident #002 on two days in May 2016, Inspector #577 noted the resident seated in a chair with a second device.

During a review of resident #002's current care plan, the Inspector found the intervention which indicated front facing apparatus.

During a record review of resident's health care records, Inspector #577 could not find a consent from the Substitute Decision Maker (SDM) for a second device. Consent was only given for the apparatus.

The home's policy titled "Least Restraint Program - LTC 3-100", last revised May 2013, indicated that staff would ensure that the resident/SDM has provided informed consent.

During an interview with the Clinical Manager #104, they confirmed that an SDM consent was not obtained for the resident's second device and consent should be always obtained from the SDM. [s. 110. (7) 4.]

(577)

3. 5. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: Consent.

During observations of resident #001 on three days in May 2016, Inspector #577 found resident seated in a special chair with an apparatus and a device. This was confirmed by OT #106, PSW #111 and RPN #120.

During a record review, Inspector found a Substitute Decision Maker (SDM) consent for an apparatus dated January 23, 2016. The consent from the SDM for the use of an apparatus did not include the second device.

During an interview with Clinical Manager #104, they confirmed that resident #001 did not have SDM consent for the second device and that it was the expectation of the home that staff obtain consent. [s. 110. (7) 4.]

6. A review of the health care records for resident #002 determined a physician's order for an apparatus when in a chair.

During observations of resident #002 on two days in May 2016, Inspector #577 noted the resident seated in a chair with a second device.

During a review of resident #002's current care plan, the Inspector found the intervention which indicated front facing apparatus.

During a record review of resident's health care records, Inspector #577 could not find a consent from the Substitute Decision Maker (SDM) for a second device. Consent was only given for the apparatus.

The home's policy titled "Least Restraint Program - LTC 3-100", last revised May 2013, indicated that staff would ensure that the resident/SDM has provided informed

consent.

During an interview with the Clinical Manager #104, they confirmed that an SDM consent was not obtained for the resident's second device and consent should be always obtained from the SDM. [s. 110. (7) 4.]

(577)

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

Sep 30, 2016(A1)

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
Toronto ON M5S 2B1
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

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

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
Toronto ON M5S 2B1
Télécopieur : 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 13 day of July 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBBIE WARPULA - (A1)

Service Area Office /
Bureau régional de services : Sudbury