Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 13, 2016	2016_384161_0054	032725-16	Resident Quality Inspection

Licensee/Titulaire de permis

KINGSWAY NURSING HOMES LIMITED
310 Queen Street East R.R. #6 ST. MARYS ON N4X 1C8

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

KINGSWAY LODGE NURSING HOME
310 QUEEN STREET EAST R.R. #6 ST. MARYS ON N4X 1C8

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

KATHLEEN SMID (161), MEGAN MACPHAIL (551)

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): on-site November 21 to 25, 2016.

During the course of the inspection, the inspector(s) observed the delivery of resident care and services, resident rooms, resident common areas, infection control practices and medication administration. The inspector(s) reviewed residents' health care records, staff work routines, Resident Council minutes, Family Council minutes and the homes' policy titled "Physical Restraint - 09-01-B" last revised 2015.

During the course of the inspection, the inspector(s) spoke with residents, family members, President of Resident Council, President of Family Council, Personal Support Workers (PSW), RAI Coordinator, Registered Practical Nurses, Registered Nurses (RN), Director of Activities, Assistant Director of Care, Director of Care (DOC) and the home's Administrator.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and compliment each other.

With regards to restraints, the home uses three forms: Pre-restraint Assessment Documentation, Resident/Family Consent to Provide Restraint and Physician's Order for Use of Restraints.

On a specified date in November 2016, resident #007 was observed sitting in a wheel chair in a tilted back position with a front closing seat belt applied. Four days later, the resident was observed sitting in the same wheel chair, not in a tilt position, with a front closing seat belt applied.

The resident's health care record was reviewed.

Resident #007 was admitted to the home in 2013. On an identified date in April 2015, the resident fell and sustained an injury. Prior to the resident's hospitalization, resident #007 did not use ambulation equipment.

On an identified date in June 2015, the resident's SDM consented to a wheel chair table top, wheel chair seat belt and recliner chair according to the Consent to Provide Restraint.

On an identified date in July 2015, more than seven weeks later, the physician signed the Physician's Order for Use of Restraints, and the following boxes are checked off: wheel

chair seat belt and wheel chair table top.

According to the most recent Physical Medication Review, signed by the physician, the resident is ordered "Restraint order as needed" and "safety: wheelchair tabletop, lapbelt, and recliner chair as needed to prevent falls".

On November 25, 2016, PSW #102 told inspector #551 that resident #007 wears the seat belt at all times, and that the use of the table top depends on the resident's mood. On the same day, RN #100 stated to inspector #551 that the use of the seat belt and table top depended on if the resident is quiet or agitated.

The DOC stated that if a resident is ordered a restraint as needed, there should be direction in the care plan stating when to apply and when to remove.

The resident's written plan of care was reviewed, and there is no indication that the resident is ordered a table top, seat belt or recliner chair, specifically as needed. The interventions include that continuation of the seat belt alarm and table top is needed, to undo and reapply the restraint at least hourly, to document hourly in the restraint record and to apply the seat belt alarm every hour and remove/readjust it every hour.

The care plan interventions are not consistent with and do not compliment the physician's orders. [s. 6. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of resident #007 collaborate with each other in the development and implementation of the restraint plan of care so that the different aspects of care are integrated and are consistent with and compliment each other, to be implemented voluntarily.

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

Findings/Faits saillants :

The licensee has failed to ensure that any device with locks that can only be released by a separate device was used in the home.

On November 22, 2016, resident #013 was observed wearing a front closing seat belt with a pin hole front closure.

The resident's health care record was reviewed.

In 2015, resident #013 had a self-propelled wheel chair for ambulation. The wheel chair had a front closing seat belt which the resident was able to undo. Resident #013 had several falls while attempting to self-transfer, including on an identified date in July 2015 when the resident hit his/her head on the floor and sustained bruising, and on an identified date in August 2015 when no injury was sustained. The following day after the identified date in August 2015, the resident's family supplied, and the home applied, a pinhole type release to the seat belt.

On November 24, 2016, RPN #106 stated that she needed to insert a pen or key into the hole to release the seat belt. She demonstrated releasing the seat belt by inserting a pen, which would be considered a separate device, into the hole. As identified in this section, any device with locks that can only be released by a separate device is prohibited. [s. 112.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for the purposes of section 35 of the Act, any device with locks that can only be released by a separate device, is not used for resident #013 nor any other resident in the home, to be implemented voluntarily.

WN #3: 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 :

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

On an identified date in November 2016, resident #013 was observed wearing a front closing seat belt.

The resident's health care record was reviewed.

Resident #013 was admitted to the home in 2011.

The resident ambulated via wheelchair and wore a front closing seat belt which the resident was able to undo. Resident #013 had several falls while attempting to self-transfer, including on an identified date in July 2015 and August 2015. On an identified date in August 2015, the resident's family supplied and applied a pinhole type release to the seat belt which the resident was unable to physically and cognitively undo.

A physician's order for the restraint was obtained on an identified date in November 2015, more than three months after the restraint was implemented.

According to the home's policy titled Physical Restraint (09-01-01-B), the Attending Physician will order the least restrictive restraint and review quarterly for ongoing need for restraint.

The resident's medication administration record (MAR) was reviewed, and there is no indication in the physician orders that the resident has a restraint and that it is reviewed quarterly. [s. 31. (2) 4.]

WN #4: 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:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

The licensee has failed to ensure that staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class.

On an identified date in November 2016, resident #008 was observed sitting in his/her wheelchair in a tilted back position with a front closing seat belt and a table top applied.

The resident's health care record was reviewed.

Resident #008 was admitted to the home in April 2014.

On an identified date in July 2015, a Physician's Order for Use of Restraints was signed by the physician and the following types of restraints are checked off: wheelchair seat belt, wheelchair table top and full length bed rails (a separate Physician's Order for Use of Restraints for bedrails has been signed by the physician on an identified date in May 2015).

On an identified date in August 2015, resident #008 was pushing him/herself downward in the wheelchair which caused the belt to tighten. The following day in August 2015, the resident was found with the seat belt around his/her upper chest, and red marks from the belt were noted. A progress note entry on the day following the incident stated that a vendor could be contacted to fix the seat belt or to assess for other options.

On an identified date in September 2015, the resident's Substitute Decision Maker requested a table top, and one was ordered on the same day.

The wheel chair table top which according to the Physician's Order for Use of Restraints was ordered by the physician on an identified date in July 2015 was not implemented until an identified date in September 2015. [s. 110. (2) 1.]

Issued on this 13th day of December, 2016

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

Original report signed by the inspector.