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
Sep 21, 2016	2016_226192_0025	023668-16	Resident Quality Inspection

Licensee/Titulaire de permis

STEEVES & ROZEMA ENTERPRISES LIMITED
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

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

LANARK HEIGHTS LONG TERM CARE CENTRE
46 LANARK CRESCENT KITCHENER ON N2N 2Z8

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

DEBORA SAVILLE (192), ADAM CANN (634), JANETM EVANS (659), SHERRI GROULX (519)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 9, 10, 11, 12, 16, 17, 18, 2016.

The following intakes were completed within the RQI:
028871-15 - IL- 37680- LO - Complaint related to Safe and Secure Home.
011341-16 - IL - 44108-LO - Complaint related to Complaint Process, Continence Care, Skin and Wound Care, Nutrition and Hydration, Infection Prevention and

Control.
011534-16, 025122-16 - IL - 44183-LO - Complaint related to Staffing, Bathing, Continence Care.
012369-16 - Complaint related to staffing.
015367-16 - Complaint related to Plan of Care, Complaint Process, Continence Care.
016845-16 - Complaint related to Plan of Care, Complaint Process, Missing items, Continence Care.
019357-16 - Complaint related to Nutrition and Hydration, Continence Care, Plan of Care.

000494-15 - Critical Incident related to the provision of oral care.
028790-15 - 2917-000020-15 - Critical Incident related to falls.
031122-15 - 2917-000025-15 - Critical Incident related to resident to resident altercations.
035731-15 - 2917-000027-15 - Critical Incident related to resident to resident altercation.
013368-16 - 2917-000004-16 - Critical Incident related to alleged staff to resident abuse.
014365-16 - 2917-000005-16 - Critical Incident related to falls.
015046-16 - 2917-000006-16 - Critical Incident related to resident to resident altercation.
015861-16 - 2917-000007-16 - Critical Incident related to alleged staff to resident abuse and falls
018320-16 - 2917-000002-16 - Critical Incident related to falls.
024442-16 - 2917-000010-16 - Critical Incident related to alleged staff to resident abuse.

004261-16 - Follow-up related to following manufacturer's instructions.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Assistant Managers of Resident Care, Registered Nurse (RN) Supervisor, Environmental Manager, Registered Practical Nurses, Personal Support Workers, Environmental Aides, Restorative Care, Dietary Aides, Kinesiologist, Registered Dietitian, Practical Nurse student, family and residents.

Inspectors toured the home, observed medication administration, medication storage areas, recreation activities, reviewed relevant clinical records, reviewed

relevant policies and procedures, the provision of resident care, resident-staff interactions, posting of required information and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **1 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 O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The Licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

Resident #041 was observed in their room, with a physical device in place.

Manufacturer instructions did not include using the device in the way the home was observed to be using it.

The licensee failed to ensure that the specified device was applied in accordance with the manufacturer's instructions. [s. 23.]

2. The Licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

A) Resident #022 was observed in a Dining Room, positioned in a chair with two devices in place.

In the presence of Registered Practical Nurse (RPN) #124 one device was moved forward revealing a second device. RPN #124 immediately stated that the second device was "not tight enough" and proceeded to tighten the device.

Interview with Kinesiologist #126 and RPN #127 who were responsible for Rehabilitation in the home stated that specified devices should be applied in a specified manner. Both staff members stated that the second device had been inappropriately applied.

During interview RPN #127 stated that resident #022 tended to slide in their chair and that Occupational Therapy was working with the resident to resolve this concern. RPN #127 confirmed that a resident who was restless in the chair and tended to slide, with a physical device in place, that was not applied according to manufacturers instructions, would potentially be at risk.

Personal Support Workers (PSW) #128 and #129 were interviewed and stated that resident #022 slides and moves in their chair. Indicating that the resident required repositioning all the time. When asked if the second device was applied correctly both PSW #128 and #129 responded "no".

The licensee failed to ensure that resident #022's physical device was applied according to manufacturer's instructions.

B) On August 11, 2016, a resident was observed with a specified device in place. Personal Support Worker (PSW) #120 had been asked by RPN #113 to demonstrate to

Inspector #192 how the restraint was secured in place. PSW #120 demonstrated how they secured the device.

The manufacturer's instructions for the restraint were requested from Rehabilitation Support #118. Staff members #118 stated that for residents who slide in their chairs or were aggressive or where other devices were not appropriate the specified device may be used. Staff member #118 described the manufacturers instructions for applying the device. When applied as demonstrated by PSW #120, the device could no longer be immediately released.

RPN Student #121 stated that they had received training on specified devices recently as part of their orientation. RPN student #121 was asked to quickly remove the device. After fumbling with the device briefly RPN Student #121 was successful in removing the device. Restorative staff member #118 attempted several times before being successful in removing the device. PSW #119 was asked to remove the device and was successful in removing the device immediately.

Inspector #659 observed Personal Support Worker (PSW) #131 remove the device from resident #041 in eight seconds.

Two of four staff knew how to immediately release the specified device.

On August 12, 2016, Kinesiologist #126 and RPN #127 stated that they had participated in instruction of all staff on devices used in the home, including the specified device. Both staff members indicated that staff had been trained to use the device according to manufacturers instructions.

The licensee failed to ensure that a specified physical device was applied according to manufacturer's instructions.

The severity of this non-compliance is minimal harm or potential for actual harm, the scope is identified to be a pattern. There was a previous compliance order related to this area of the legislation that had been issued in relation to a December 29, 2015, inspection with a compliance date of February 26, 2016. [s. 23.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

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

The plan of care for resident #028 was reviewed and failed to address the risk of harm to the resident related to the potential for altercations between the resident and wandering residents from other home areas, who enter the residents room.

The Power of Attorney (POA) for resident #028 met with the Administrator of the home to discuss concerns that resident's were entering resident #028's room.

During interview with the POA it was identified that resident #028 had been threatened by a resident.

Resident #028's room mate stated that residents enter the room daily, at times demonstrating aggression.

When asked if they felt threatened by the residents entering their room both resident #028 and the room mate responded that they did feel threatened.

It was observed that interventions were in use to deter others from entering resident

#028's room but were not always complied with by staff.

Interview with Administrator #100 on August 18, 2016, confirmed that resident #028's POA had spoken with Administrator #100 and that a specified intervention was to be in place. Administrator #100 indicated that Behaviour Support Staff were to be following up in relation to the concerns.

During interview on August 18, 2016, PSW #134 stated that she was aware that residents wandered onto the home area and described interventions specific to some of the wandering residents. PSW #134 stated that staff on the specified home area did not know the specific needs for some wandering residents and may not know how to safely provide care to those residents. No plan was currently in place for the sharing of information with staff from the home area with regard to the care of wandering residents from other home areas. PSW #134 confirmed that residents wandered onto the home area.

Residents were observed by Inspector #659 wandering onto the specified home areas.

The licensee failed to ensure that there was a written plan of care for each resident that set out, clear directions to staff and others who provide direct care to the resident when the use of the specified device to prevent residents from wandering into resident #028's room was not included in the plan of care.

The severity of this non-compliance is minimal harm or potential for actual harm risk, the scope is isolated. This area of non-compliance was previously issued during inspection initiated July 7, 2015 as a VPC and September 22, 2014 as a VPC. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement.

The Registered Nurse (RN) staffing sheets for the home were reviewed on August 17, 2016, and revealed that on April 6, 2016, the regular full time RN scheduled to work 1500 hours to 2300 hours was not in attendance at the home. The documentation showed that an Agency RN was utilized to fill this vacancy.

During interview with the Manager of Resident Care (MRC) #101 on August 17, 2016, at 1330 hours, she stated that on April 6, 2016, they were short a RN for the evening shift (1500-2300 hours). They were able to have the Resident Assessment Instrument (RAI) RN stay until 1800 hours and the night RN come in early at 2100 hours, but the Agency RN was alone in the home from 1800 hours until 2100 hours.

The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times when an Agency RN was the only RN in the home for three hours, and the home was not allowed an exception due to a bed count of 160.

The severity of this non-compliance is minimal harm or potential for actual harm, the scope is isolated. There was no previous compliance history. [s. 8. (3)]

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 ensuring that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Resident #023 was identified in the plan of care under Eating Self Performance to require supervision, staff to provide encouragement and cueing and under Eating to require set-up assistance only.

Observation identified that resident #023 was provided fluids at the beginning of the meal, at 1203 hours, soup was provided which the resident attempted to eat

independently, at 1217 hours a sandwich and vegetables were placed in front of the resident. The resident sat with the meal in front of them until 1225 when a staff member came to the table to encourage the resident to eat the sandwich. The resident was able to complete the sandwich and did not attempt to eat the vegetables on the plate. No further staff encouragement or assistance was provided until 1303 hours when a staff member approached and encourage the resident to drink their hot beverage. The resident then drank the hot beverage. At 1310 hours a staff member approached the resident and encouraged drinking a cold beverage, which the resident then consumed. Supplement was provided to the resident at the beginning of the lunch meal by the Registered Practical Nurse and was not touched by the resident until 1303 hours after a staff member encouraged drinking the supplement. The supplement was then consumed.

Resident #023 was identified by the Power of Attorney and the medical record to be a poor eater and had sustained weight loss of greater than five percent in a specified month. The Registered Dietitian had initiated interventions to promote weight gain.

Record review identified that the Registered Dietitian had stated in a specified progress note that the resident's intake was variable and that they required "++ encouragement", "continue to encourage food and fluid intake at meals".

During interview Registered Practical Nurse (RPN) #147 stated that resident #023 should have received more encouragement and more timely encouragement to complete their meal.

The licensee failed to ensure that resident #023 received encouragement required to eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

2. The Licensee failed to ensure that proper techniques were used to assist resident with eating, including safe positioning of residents who require assistance.

Inspector #659 observed Registered Practical Nurse (RPN) #113 standing while feeding resident #003. The resident was observed coughing intermittently while being assisted to drink. In an interview with RPN # 113 she acknowledged that she should have been sitting when providing the nourishment.

On August 12, 2016, it was observed that residents #042 and #043 were not safely positioned for eating.

During interview with Personal Support Worker (PSW) #132, he stated that he had raised the head of the resident's beds to approximately 45 degrees. RPN #113 observed resident #043 on August 17, 2016, immediately following the provision of the snack and stated that the resident had not been correctly repositioned to provide the snack; resident #043 should have been positioned on their back with the head of the bed elevated.

Manager of Resident Care (MRC) #113 stated that the expectation was staff were to sit at eye level (squat or use the stool that was on the nutrition cart) and that the resident should be safely positioned with the head of bed elevated or if the resident did not want this and wished to lie flat this should be care planned.

The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

The severity of this non-compliance is minimal harm or potential for actual harm. The scope is isolated. There was no previous compliance history. [s. 73. (1) 10.]

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 ensuring that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Inspector #659 observed Personal Support Worker (PSW) #132 enter three specified rooms to assist residents #042 and #043 with their afternoon snack; and to provide a snack to resident #045 and #030. PSW #132 failed to cleanse his hands between providing assistance and snacks to the residents.

PSW #132 was interviewed and said that he had not cleansed his hands between assisting residents to eat their snacks on August 12, 2016.

Registered Practical Nurse (RPN) #113 was interviewed and stated that the expectation was that sanitizer was utilized between the provision of care.

The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

The severity of this non-compliance is identified to be minimal harm or potential for actual harm, the severity is isolated. This area of non-compliance was previously issued as a VPC during the 2015 RQI initiated on July 7, 2015 and the 2014 RQI initiated September 22, 2014. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #048's plan of care stated that the resident's bath was to occur twice weekly on specified days.

During an interview with the Manager of Resident Care (MRC) #101 the inspector requested documentation to verify if resident #048 received their bath on specified days 2016. The MRC was able to provide documentation that resident #048 received a bed bath on one occasion, but was unable to find documentation that they had received the second bath.

During an interview with MRC #101 she stated that she spoke with two Personal Support Workers (PSWs) who were working the specified day. PSW #146 stated that she believed that she had given the bath, but admitted to not documenting the bath. MRC #101 stated it was the expectation of the home that care given to residents was documented.

The severity of this non-compliance was identified to be minimum risk, the scope was isolated. Non-compliance was previously issued as a VPC during the RQI initiated on July 7, 2015. [s. 30. (2)]

Issued on this 21st day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192), ADAM CANN (634), JANETM EVANS (659), SHERRI GROULX (519)
Inspection No. / No de l'inspection :	2016_226192_0025
Log No. / Registre no:	023668-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 21, 2016
Licensee / Titulaire de permis :	STEEVES & ROZEMA ENTERPRISES LIMITED 265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	LANARK HEIGHTS LONG TERM CARE CENTRE 46 LANARK CRESCENT, KITCHENER, ON, N2N-2Z8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Hildy Nickel

To STEEVES & ROZEMA ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_260521_0059, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff use all equipment supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The plan is to include, but is not limited to:
1. Training of staff on the use of assistive aids, devices, and positioning aids including the Posey Pelvic restraint and front closing seat belts.
2. A monitoring process to ensure that staff continue to apply devices according to manufacturers instructions.

The plan shall be submitted electronically to Debora Saville, Long-term Care Homes Inspector, London Service Area Office, Ministry of Health and Long Term Care, Long Term Care Homes Inspection Division, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2 at debora.saville@ontario.ca by September 30, 2016.

Grounds / Motifs :

1. The Licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

A) Resident #022 was observed in a Dining Room, positioned in a chair with two devices in place.

In the presence of Registered Practical Nurse (RPN) #124 one device was moved forward revealing a second device. RPN #124 immediately stated that

the second device was "not tight enough" and proceeded to tighten the device.

Interview with Kinesiologist #126 and RPN #127 who were responsible for Rehabilitation in the home stated that specified devices should be applied in a specified manner. Both staff members stated that the second device had been inappropriately applied.

During interview RPN #127 stated that resident #022 tended to slide in their chair and that Occupational Therapy was working with the resident to resolve this concern. RPN #127 confirmed that a resident who was restless in the chair and tended to slide, with a physical device in place, that was not applied according to manufacturers instructions, would potentially be at risk.

Personal Support Workers (PSW) #128 and #129 were interviewed and stated that resident #022 slides and moves in their chair. Indicating that the resident required repositioning all the time. When asked if the second device was applied correctly both PSW #128 and #129 responded "no".

The licensee failed to ensure that resident #022's physical device was applied according to manufacturer's instructions.

B) On August 11, 2016, a resident was observed with a specified device in place. Personal Support Worker (PSW) #120 had been asked by RPN #113 to demonstrate to Inspector #192 how the restraint was secured in place. PSW #120 demonstrated how they secured the device.

The manufacturer's instructions for the restraint were requested from Rehabilitation Support #118. Staff members #118 stated that for residents who slide in their chairs or were aggressive or where other devices were not appropriate the specified device may be used. Staff member #118 described the manufacturers instructions for applying the device. When applied as demonstrated by PSW #120, the device could no longer be immediately released.

RPN Student #121 stated that they had received training on specified devices recently as part of their orientation. RPN student #121 was asked to quickly remove the device. After fumbling with the device briefly RPN Student #121 was successful in removing the device. Restorative staff member #118 attempted

several times before being successful in removing the device. PSW #119 was asked to remove the device and was successful in removing the device immediately.

Inspector #659 observed Personal Support Worker (PSW) #131 remove the device from resident #041 in eight seconds.

Two of four staff knew how to immediately release the specified device.

On August 12, 2016, Kinesiologist #126 and RPN #127 stated that they had participated in instruction of all staff on devices used in the home, including the specified device. Both staff members indicated that staff had been trained to use the device according to manufacturers instructions.

The licensee failed to ensure that a specified physical device was applied according to manufacturer's instructions. (192)

2. The Licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

Resident #041 was observed in their room, with a physical device in place.

Manufacturer instructions did not include using the device in the way the home was observed to be using it.

The licensee failed to ensure that the specified device was applied in accordance with the manufacturer's instructions.

The severity of this non-compliance is minimal harm or potential for actual harm, the scope is identified to be a pattern. There was a previous compliance order related to this area of the legislation that had been issued in relation to a December 29, 2015, inspection with a compliance date of February 26, 2016. (659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE

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