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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 2, 2017	2016_395613_0022	033021-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE ONTARIO-FINNISH RESTHOME ASSOCIATION
725 North Street Sault Ste Marie ON P6B 5Z3

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

MAUNO KAIHLA KOTI
723 North Street Sault Ste Marie ON P6B 6G8

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

LISA MOORE (613), JENNIFER LAURICELLA (542)

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): December 12 - 16, 2016

Additional logs inspected during this RQI include:
Three critical incident reports submitted by the home related to resident falls resulting in injury and hospitalization.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Executive Director of Care (EDOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Executive Administrative Specialist (EAS), Unit Clerk (UC), residents and family members.

During the course of the inspection, the Inspectors conducted a daily walk through of the resident home areas and various common areas, made direct observation of the delivery of care and services provided to the residents, observed staff to resident interactions, reviewed health care records and various policies, procedures and programs of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were assessed and their bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the residents.

During the inspection, residents #001, #002 and #003 were identified as requiring further inspection related to potential bed rail restraints.

On December 14, 2016, Inspector #613 observed resident #001 to have a bed rail in the guard position on their bed and resident #003 to have bed rails in the guard position on their bed. Neither resident were in their beds when the bed rails were in the guard position. On the same date, Inspector #542 observed resident #002 in bed with their bed rails in the guard position.

Inspector #613 completed a health care record review for residents #001 and #003, which identified resident #001's bed rail was used as a personal assistance services device (PASD) and resident #003's bed rails were used as a physical device to restrain. The Inspector reviewed the electronic progress notes on MED e-care which identified that resident #001's bed system was evaluated in December 2016, and resident #003's bed system had been evaluated in August 2016. The e-notes on MED e-care did not identify that a resident assessment had been conducted to assess and determine the use of the bed rails for residents #001 and #003.

Inspector #542 completed a health care record review for resident #002, which identified resident #002 used bed rails in the guard position while in bed for positioning and safety.

Inspector #542 determined that the bed system had been evaluated and was unable to locate a resident assessment for the use of the bed rails.

Inspector #613 reviewed policy titled " Minimizing Restraints of Residents" last revised June 2016, which identified under an assessment heading, that registered staff (RPN Team Leader and RN Supervisor) would assess the resident for condition, circumstances or clinical indicators that potentially required treatment interventions, such as bed rail restraints. Staff was to identify and document precipitating factors including the clinical indicator(s) that may necessitate the use of physical environmental restraint.

On December 14, 2016, Inspector #613 interviewed RPN #104, who stated that the registered staff visually assessed the resident, but did not document the resident assessment in the health care records. The RPN stated the home does not a have clinical assessment tool or process to use to complete an assessment on the resident for bed rail use.

On December 16, 2016, Inspector #613 interviewed RN #110, who confirmed there was no documentation to support that residents #001, #002 and #003 had been assessed to determine the use of the bed rails. The RN stated, they were currently working on an assessment tool for registered staff to use and document on and currently registered staff used their nursing judgement for the use of bed rails on the resident's beds.

On December 16, 2016, Inspector #613 interviewed the Executive Director of Care (EDOC), who confirmed residents #001, #002 and #003 had not been assessed for the use of bed rails and stated it was their expectation that registered staff assessed all residents prior to the use of bed rails. [s. 15. (1) (a)]

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 residents #001, #002 and #003 were assessed and their bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the residents, to be implemented voluntarily.

WN #2: 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:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk.

During the inspection, resident #002 was identified as requiring further inspection related to restraint use.

On December 13 and 14, 2016, Inspector #542 observed resident #002 in their wheel chair with a safety device applied. On December 14, 2016, resident #002 was observed in bed with bed rails in the guard position.

Inspector #542 completed a health care record review for resident #002. The current care plan identified that resident #002 used bed rails and a safety device on their wheel chair as restraints. The health care record did not identify alternatives that were considered or tried.

On December 16, 2016, Inspector #542 interviewed PSW #106 and asked if they had tried any alternatives for restraining for resident #002. PSW #106 stated that after resident #002 sustained an injury, all of the restraints where put in place. Inspector #542 interviewed RPN #104 who also verified that no other alternatives to restraining were considered or tried for resident #002. [s. 31. (2) 2.]

2. During the inspection, resident #003 was identified as having a potential bed rail restraint.

Inspector #613 observed resident #003 to have bed rails in the guard position on their bed.

The Inspector completed a health care record review for resident #003, which identified the bed rails were used as a physical device to restrain. The documentation in e-notes on MED e-care and in the paper chart did not identify that any other alternatives were tried prior to the use of the restraint being implemented.

On December 14, 2016, Inspector #613 interviewed RPN #104, who stated that no other alternatives to the use of the restraints had been considered, and tried.

On December 16, 2016, the Inspector interviewed RN #110, who was unsure if alternatives had been considered or tried. RN stated they would check resident #003's health care record but were unable to provide documentation to the Inspector that alternatives had been considered or tried.

Inspector # 613 reviewed the home's policy titled, "Minimizing of Restraints of Residents" last revised June 2016, which identified staff were to trial and document the outcomes of all alternative interventions to restraining.

On December 16, 2016, the Inspector interviewed the EDOC, who confirmed that staff were to trial different interventions prior to use of bed rails restraint. [s. 31. (2) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraint plan of care includes alternatives to restraining are considered and tried, but have not been effective in addressing the risk for residents #002 and #003 and all other residents that have restraints, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector #542 reviewed a Critical Incident Report (CI) that was submitted to the Director in June 2016, which indicated resident #008 had a fall that resulted in an injury.

The Inspector reviewed resident #008's health care record, which did not identify that a post falls assessment, using a clinically appropriate assessment instrument that was specifically designed for falls, had been completed after the fall. The care plan at the time of the fall, indicated that resident #008 was at a high risk for falls.

On December 14, 2016, RN #105 provided Inspector #542 with a blank copy of the home's "Resident Incident Report" and the "Falls Assessment Checklist - Lower Extremities #0607-01" that the home used as their clinically appropriate assessment instrument that was specifically designed for falls.

On December 16, 2016, Inspector #542 interviewed RPN #104, who indicated that they were required to complete a post falls assessment after each fall and showed the Inspector the form titled, "Fall Assessment Checklist - Lower Extremities #0607-01" which they considered the home's clinically appropriate assessment instrument; however, they stated the form was sometimes not completed. [s. 49. (2)]

2. Inspector #542 reviewed a Critical Incident Report (CI) that was submitted to the Director in July 2016, which indicated that resident #009 had a fall that resulted in a transfer to the hospital.

The Inspector reviewed resident #009's health care record, which did not identify that a

post falls assessment, using a clinically appropriate assessment instrument, that was specifically designed for falls, had been completed after the fall. The care plan at the time of the fall indicated that resident #009 was at a high risk for falls. [s. 49. (2)]

3. Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director in November 2016, that identified resident #010 had a fall in November 2016, which resulted with a transfer to hospital and a diagnosed injury.

The CI report identified that the resident had several other falls since September 2016 due to self-transferring.

The Inspector completed a health care record review and reviewed the investigation file provided by the EDOC for resident #010 in regards to their fall in November 2016, which did not identify that a post falls assessment, using a clinically appropriate assessment instrument that was specifically designed for falls, had been completed.

The Inspector interviewed RN #105, who indicated that a post falls assessment should have been completed by the registered staff after each resident fall. RN #105 reviewed resident #010's entire health care record and confirmed to the Inspector that a post falls assessment, using a clinically appropriate assessment instrument that was specifically designed for falls, had not been completed for resident #010's fall. RN #105 confirmed registered staff should have completed the post falls assessment.

On December 16, 2016, Inspector #613 interviewed the EDOC, who confirmed that registered staff were expected to complete a post falls assessment using the "Post Falls Assessment Checklist - Lower Extremities, #0607-01" after every resident fall. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when residents #008, #009 and #010 fall, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, supplies, devices and positioning aids were readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

During the inspection, resident #005 was identified as requiring additional inspection regarding an area of altered skin integrity.

Inspector #542 completed a health care record review for resident #005. The current care plan identified that resident #005 had altered skin integrity. The Inspector reviewed the physician's order for October 2016, which identified that a specific treatment was to be applied to the altered skin integrity. During a review of the electronic progress notes (e-notes), the Inspector noted it was documented in October 2016, that the specific treatment had not been received and there had been no follow-up by staff to ensure that the specific treatment would be received for the altered skin integrity care. In October 2016, the order had been discontinued.

On December 14, 2016, Inspector #542 interviewed RPN #104, who verified that the home had never received the specific treatment for resident #005's area of altered skin integrity and that the physician's order had not been followed for 8 days. [s. 50. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that equipment, supplies, devices and positioning aids is readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing, to be implemented voluntarily.

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. (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).

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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

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 consent was documented.

During the inspection, resident #003 was identified as requiring further inspection related to a bed rail restraint.

Inspector #613 observed resident #003 to have bed rails in the guard position on their bed on December 14, 2016. The resident was not in the bed.

On December 14, 2016, the Inspector interviewed PSW #106, who stated the resident had used bed rails on their bed, since their admission in April 2016. The PSW stated the bed rails were considered a restraint.

Inspector #613 completed a health care record review for resident #003 which identified the bed rails were used as a physical device to restrain. The Inspector reviewed a form titled, "Consent for Use of Restraining Device" for bed rails while in bed, dated July 8, 2016, that was signed by RPN #104, who had received verbal consent from the resident's substitute decision-maker via telephone conversation for use of the bed rails. A review of the paper chart, identified that a phone order was received in April 2016 by the home's Medical Director for the bed rails with a specific device attached, while in bed. The electronic and paper health care records did not identify that consent for the use of the bed rails had been received in April 2016, but in July 2016, two and half months after the bed rail order was received and implemented.

On December 16, 2016, the Inspector interviewed RPN #104, who confirmed resident #003 had used bed rails since their admission, April 2016. The RPN reported to the Inspector that they felt they had called the substitute decision-maker to receive a verbal consent, after the bed rails had been ordered by the physician on resident #003's admission. RPN #104 further stated, during a restraint audit in July 2016, they had determined there was no signed consent form on the resident's paper chart. RPN #104 stated they had then received a verbal consent from resident #003's substitute decision-maker (SDM) for the use of the bed rails in July 2016.

On December 16, 2016, the Inspector interviewed RN #104, who stated that the bed rails were used since resident #003's admission, but the home had difficulty reaching the resident's SDM to sign the consent form. The RN confirmed that verbal consent for the use of the bed rails had not been received until July 2016.

Inspector # 613 reviewed the home's policy titled, "Minimizing Restraints of Residents" last revised June 2016, that identified that registered staff would discuss the use of the restraint with the SDM, obtain consent and complete the Consent for Restraint Use form. Then contact the Medical Director/Nurse Practitioner (MD/NP) for the restraint written order with specific instructions. [s. 110. (7) 4.]

2. 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, every release of the device and all repositioning.

During the inspection, resident #002 was identified as requiring further inspection related to the use of restraints.

On December 13 and 14, 2016, Inspector #542 observed resident #002 in their wheel chair with a safety device applied. On December 14, 2016, Inspector #542 observed resident #002 in bed with bed rails in the guard position.

Inspector #542 completed a health care record review for resident #002. The current care plan identified that resident #002 had bed rails and a safety device in their wheel chair as restraints.

Inspector #542 reviewed the home's form titled, "Restraint and PASD Care Flow Record" that was used by the PSW staff to document when the resident was repositioned and the restraint was released in regards to their safety device. The following was documented;

-Two dates in November 2016, the safety device restraint was applied at a specific time; however, there was no documentation for three hours to indicate whether the resident was repositioned or the restraint had been released,

-A specific date in November 2016, the safety device restraint was applied at a specific time; however, there was no documentation until the next day as to whether resident #002 was repositioned or if the restraint had been released,

-And three other specific dates in November 2016, there was no documentation from a specific time until the next day at a specific time,

On December 16, 2016, Inspector #542 interviewed PSW #106, who indicated that every release of the device and all repositioning was to be documented on the form titled, "Restraint and PASD Care Flow Record". [s. 110. (7) 7.]

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 every use of a physical device to restrain a resident under section 31 of the Act, that the consent is documented and every release of the device and all positioning is documented, to be implemented voluntarily.

WN #6: 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. (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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During the inspection, resident #005 was identified as requiring further inspection related to a worsening area of altered skin integrity.

Inspector #542 completed a health care record review for resident #005. The current care plan identified under the problem statement "Skin Integrity" that resident #005 was to be transferred into bed every day at a specific time.

On December 14, 2016 at a specific time, Inspector #542 observed resident #005 sitting in their wheel chair in an area of the home.

The Inspector interviewed PSW # 106 and asked if the resident had been up in their wheel chair all morning and afternoon. The PSW stated that it was the resident's bath day and confirmed that resident #005 had been up in their wheel chair all day and not transferred to bed at the specific time as indicated in their care plan. [s. 6. (7)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

During the course of the inspection, Inspector #542 and #613 observed resident #002, #003, #006, #012 in their wheelchairs. Both Inspectors observed the above residents to have soiled wheelchairs during the course of the inspection.

On December 14, 2016, Inspector #542 interviewed RPN #104 and PSW #111, who both verified that some of the resident's wheel chairs were soiled and had not been cleaned adequately. [s. 15. (2) (a)]

Issued on this 8th day of February, 2017

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

Original report signed by the inspector.