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
Dec 06, 2016;	2016_391603_0019 (A1)	011645-16	Resident Quality Inspection

Licensee/Titulaire de permis

675412 ONTARIO INC
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

NORTHVIEW NURSING HOME
77 RIVER ROAD P.O. BOX 1139 ENGLEHART ON P0J 1H0

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

SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date extension for CO#001, 002, 003, 004, 005, from December 7, 2016, to December 31, 2016 and CO#006 rescinded.

Issued on this 6 day of December 2016 (A1)

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

Original report signed by the inspector.

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SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 8 - 12, 2016.

During the course of the inspection, the inspector(s) directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures, and programs, reviewed staff education attendance records, and reviewed critical incident reports sent to the Ministry of Health and Long-Term Care.

One log submitted to the Ministry of Health and Long-Term Care was completed during the inspection and was related to a disease outbreak.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (ADM/DOC), Assistant Director of Care (ADOC), Director of Therapeutic and Recreations Services, Registered Dietitian, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents, and Family Members.

The following Inspection Protocols were used during this inspection:

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Residents' Council

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
5 ~~4~~ VPC(s)
5 ~~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. (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).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 plan of care set out clear directions to the staff and others who provided direct care to the resident.

During the inspection, Inspector #603 observed resident #005 sitting in a wheelchair with an assistive device. Resident #005 explained that they wanted the assistive device in place. Resident #005 also explained that they were able to apply and remove the assistive device as needed, and demonstrated that they could.

Inspector #603 reviewed resident #005's health care record which identified a physician order for a Personal Assistance Service Device (PASD) consisting of the above assistive device to be applied, while the resident was in their wheelchair.

Inspector #603 reviewed the resident's care plan which indicated a focus for "Physical Restraint Use FFSB". The interventions included that staff were to: apply the assistive device when the resident was up in their wheelchair, check the resident and release the device as per facility protocol; check the resident hourly and release the device every two hours. Inspector #603 also noted a "Restraint Flow Sheet" for resident #005, which identified the assistive device as a restraint, and the staff had documented hourly checks for the restraint.

According to the LTCHA 2007, 30. (1) (2), The use of a physical device from which a resident is both physically and cognitively able to release themself is not a restraining of the resident.

Inspector #603 interviewed PSW #107 who explained that resident #005 did not have a restraint. The assistive device was used to help the resident with positioning and the resident was capable of applying and removing the assistive device as needed. PSW #107 could not explain why the staff were documenting on the restraint flow sheet and later explained that they had brought this issue forward to management and nothing had been changed. [s. 6. (1) (c)]

2. During the inspection, it was determined that resident #001 had a weight loss of five per cent or more in a one month period. Inspector #575 reviewed the resident's electronic care plan in Point Click Care (PCC) and under the focus of communication problem and endocrine system, there were no interventions. Under the focus activities of daily living, the interventions related to eating stated the following: Eating: resident is able to (specify: hold cup, feed self, eat finger foods independently), therefore, it was incomplete.

Inspector #603 interviewed the ADOC who explained that only RNs and RPNs have access to the electronic care plan. The PSWs review the kardex or the paper care plan in the resident's chart as needed. The kardex only had interventions and not the complete care plan.

Inspector #575 reviewed resident #001's kardex and paper care plan. The Inspector noted that the kardex was printed in October 2015 . The Nutrition Risk identified that the resident had a certain body mass index (BMI) in April 2015, with no change in weight within the past six months to a year. The paper care plan did not include a date and indicated that the resident had difficulty chewing harder textured foods.

Inspector #575 interviewed the Administrator regarding the plans of care. The Inspector showed the Administrator the kardex printed. The Administrator confirmed that PSWs reviewed the kardex as a quick reference and that the kardex was printed from the previous electronic system (Med e-care). The Administrator also confirmed that they were still in the process of switching over information into the plans of care from Med-e-care to PCC. The Inspector showed the Administrator the resident's current electronic care plan from PCC. The

Administrator confirmed that the kardex was not the most recent and that the PCC care plan was not up to date.

During an interview with Inspector #575, RN #110 stated that they were not sure how often or who updated the kardexes.

Inspector #575 interviewed PSW #108 and #109 regarding how they are provided directions on the type of care a resident required. They stated that they would review the kardex; however, they were rarely up to date. They stated that they used to look at the paper care plan in the resident's chart when they were located at the nursing station; however, they were now located in the doctor's room and they rarely go in this room. PSW #108 stated that it is difficult because depending on what RN was working, they will direct care differently. Due to the kardex not being up to date and depending on what RN was working, they do not have clear directions on what type of care is required for residents. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

During the inspection, Inspector #603 observed resident #005 sitting in a wheelchair with an assistive device applied. Resident #005 explained that they wanted the assistive device in place. Resident #005 also explained that they were able to apply and remove the assistive device as needed, and demonstrated that they could.

Inspector #603 reviewed the resident's care plan which indicated a focus for "Physical Restraint Use FFSB". The interventions included that staff were to: apply the assistive device when the resident was up in their wheelchair; check the resident and release the device as per facility protocol; check the resident hourly and release the device every two hours.

Inspector #603 reviewed resident #005's health care record which identified a physician order for a PASD consisting of the assistive device while in their wheelchair. The health care record did not include any assessment regarding the resident's need for a PASD as per physician order or a restraint as per the care plan.

Inspector #603 interviewed RN #104 who could not find any assessments completed for any assistive or restraining device, and could not explain how the

decision was made to apply the assistive device to the resident.

The Inspector interviewed the ADOC who confirmed that there was no assessment completed to determine the need or preference for the resident's assistive device.

Inspector #603 reviewed the home's policy titled: "Restraints (CN-R-05-1)", dated February, 2016. The policy indicated: "The home shall ensure that a PASD used to assist a resident with a routine activity of living with or without limitations of movement have all of the following included/documented on the resident's plan of care.
1. Alternatives to the use of a PASD have been considered, and tried where appropriate;
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. Approval and consent of the restraint.
4. In addition to the assessments, re-assessments and monitoring in the requirements for use of restraints and PASDs, any resident who is using a restraint or PASD will have the following completed upon admission, at least quarterly and with any change in condition that impacts the use of restraints/PASDs: MDS RAI assessment, Restraint RAP, resident safety assessment which includes the evaluation of risk factors, alternatives considered and trialed, and care plan reviewed and updated as required". [s. 6. (2)]

4. During the inspection, Inspector #603 observed resident #003 sitting in a specific wheelchair with an assistive device applied.

Inspector #603 interviewed the ADOC who explained that resident #003 required the assistive device and a specific wheelchair to prevent them from reaching out and falling out of their wheelchair. The ADOC confirmed that the resident was not capable of removing the assistive device and for this reason, both the assistive device and the specific wheelchair were considered restraints.

Inspector #603 reviewed resident #003's care plan which indicated a focus for "Restraints" and the interventions included the assistive device and a specific wheelchair to maintain safety, and to prevent entrapment and bodily injury. Inspector #603 also reviewed the resident's health care record which did not include any assessment regarding the resident's needs for restraints; however,

there was a "Restraint/PASD and Alternative Assessment" form which indicated that it "must be completed prior to initial restraint/PASD application, minimum quarterly and with change in condition that impacts use of restraint/PASD". This form was not completed.

Inspector interviewed the ADOC who confirmed that there was no assessment completed to determine the need for an assistive device or the specific wheelchair (restraints) and the "Restraint/PASD and Alternative Assessment" form was not completed.

Inspector #603 reviewed the home's policy titled: "Restraints (CN-R-05-1), dated February, 2016". The policy indicated: "Every use of a physical device to restrain a resident is documented and includes the circumstances precipitating the application of the physical device; what alternatives were considered and why those alternatives were inappropriate; all assessments and reassessments, including the resident's responses. [s. 6. (2)]

5. On a certain date, at 1018 hours, Inspector #603 observed resident #006 sitting in a specific wheelchair. At 1245 hours, Inspector #603 observed resident #006 sitting in a wheelchair with an assistive device applied.

Inspector #603 reviewed the resident's care plan which indicated a focus for "Physical Restraint Use FFSB and tilt chair". The interventions included that the assistive device was to be applied when the resident was in their wheelchair, and if the wheelchair was in a certain position, staff were to remove the assistive device.

Inspector #603 reviewed resident #006's health care record which did not identify an assessment of the resident need for restraints.

Inspector #603 interviewed RN #104 who did not find any assessment for restraints completed and could not explain how the decision was made to apply the restraints.

Inspector #603 interviewed the ADOC who confirmed that there was no assessment completed on resident #006 to determine the need for a restraint. [s. 6. (2)]

6. 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.

On a certain date, at 0845 hours, Inspector #603 observed resident #003 sitting in the dining room, in their wheelchair with an assistive device applied. Between 0845 hours and 1215 hours, the Inspector intermittently observed resident #003 continuing to sit in their wheelchair with their assistive device in place. At 1215 hours, the resident was leaning forward, reaching out and was agitated.

At 1215 hours, Inspector #603 interviewed PSW #111 who was caring for resident #003. PSW #111 explained that they had assisted resident #003 out of bed at 0730 hours and had repositioned them in their wheelchair at 0830 hours because the resident was leaning on their right side. PSW #111 also explained that it was the home's expectation that a resident who was sitting in a wheelchair with an assistive device, would be checked every hour and would be repositioned every two hours. PSW #111 also explained that they had not repositioned the resident since 0830 hours and thought that the other two PSWs (#107 and #112) had repositioned resident #003.

Inspector #603 (with PSW #111 in attendance) interviewed PSW #107 and #112 and both PSWs denied repositioning resident #003 since 0830 hours.

Inspector #603 reviewed resident #003's care plan which revealed a focus for "Restraints". The interventions included an assistive device while sitting in their wheelchair and for the wheelchair to be positioned as needed. Every hour, the resident would be checked for safety and every two hours, the resident would be repositioned. In this case, the resident was not repositioned between 0830 hours and 1215 hours or every 2 hours. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001,002

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 plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).

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:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

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

During the inspection, Inspector #603 observed resident #003 sitting in a specific wheelchair with an assistive device applied.

Inspector #603 interviewed RN #104 who explained that resident #003 required an assistive device and a specific wheelchair to prevent them from reaching out and falling. The Inspector also interviewed the ADOC who confirmed that resident #003 required two physical restraints: a specific assistive device and a specific wheelchair. The ADOC also confirmed that resident #003 was not able to remove the assistive device on their own.

Inspector #603 reviewed resident #003's care plan which revealed a focus for "Restraints", which indicated that resident #003 required the assistive device on their wheelchair for a specific reason and at times required their wheelchair in a certain position, to prevent certain movements.

Inspector #603 reviewed resident #003's health care record which did not include a physician or a registered nurse in the extended class order for the assistive device and or the specific wheelchair as a restraint.

An interview with the ADOC confirmed that there was no physician or registered nurse in the extended class order for the two physical restraints.

Inspector #603 reviewed the home's policy titled "Restraint #CN-R-05-4", which indicated that prior to physical restraint use, a physician or registered nurse in the extended class must order a restraint. The order must clearly indicate the type of restraint, when and where it is to be used, the detailed reason for use and any special instructions for use. The order must be included in the care plan. [s. 31. (2) 4.]

2. On a certain date, at 1018 hours, Inspector #603 observed resident #006 sitting in a specific wheelchair. At 1245 hours, Inspector #603 observed resident #006 sitting in a wheelchair with an assistive device applied.

Inspector #603 interviewed RN #104 who explained that resident #006 required the assistive device and or a specific wheelchair to prevent the resident from falling out of their wheelchair.

Inspector #603 reviewed resident #006's health care record which revealed no order by the physician or the registered nurse in the extended class for the assistive device or a specific wheelchair as restraints.

Inspector #603 interviewed the ADOC who confirmed that there was no order for the assistive device and/or a specific wheelchair as a form of restraints. [s. 31. (2) 4.]

3. The licensee has failed to ensure that the restraint plan of care included the consent by the resident or if the resident was incapable, by the Substitute Decision Maker (SDM).

On a certain date, at 1018 hours, Inspector #603 observed resident #006 sitting in a specific wheelchair. At 1245 hours, Inspector observed resident #006 sitting in a wheelchair, with an assistive device applied.

Inspector #603 interviewed RN #104 who explained that resident #006 required restraints such as the assistive device and or a specific wheelchair to prevent the resident from falling out of their wheelchair.

Inspector #603 reviewed the resident's health care record which revealed a consent for the assistive device but no consent for a specific wheelchair as a form of restraint.

Inspector #603 interviewed the ADOC who confirmed that there was no documented consent for a specific wheelchair as a restraint, by resident #006 or their Substitute Decision Maker (SDM). [s. 31. (2) 5.]

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

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 restraint plan of care includes the consent by the resident or if the resident was incapable, by the SDM, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) Inspector #603 reviewed the home's policy titled "Restraints" dated February, 2016, which indicated the permitted physical restraints used in the home. These included: seat belts, table tops, and side rails. There was no mention of tilted wheelchairs as a permitted physical restraint. Furthermore, the policy indicated "Failure to follow the policy and misuse of restraints constituted abuse".

During the inspection, Inspector #603 observed numerous times, two different residents tilted in wheelchairs.

Inspector #603 interviewed the Administrator who explained that tilted wheelchairs were not considered a restraint as per the home's restraint policy; however, the front line staff were using tilted wheelchairs as physical restraints for different residents.

b) Inspector #603 reviewed the home's policy titled "Restraints" dated February, 2016, which indicated that "All appropriate staff are to be aware at all times of when a resident is being restrained by use of a physical device. Staff are to be notified at the change of shift report of residents who are being restrained by use of a physical device or PASD with restraining properties".

During the inspection, Inspector #603 interviewed PSW #112 who explained that

they had received report that morning and there was no discussion about restrained residents. PSW #112 further explained that at shift report, there was never a report on which resident was restrained unless there was a new intervention or a change to a restraint.

Inspector #603 interviewed the Administrator who explained that the home's expectation was that only if a new restraint is identified or there has been a change to a restraint will the staff discuss restraints at shift report. The Administrator further explained that "the only exception of a new restraint would be communicated and the restraints would not be documented on the shift report".

Inspector #603 reviewed the shift report for a specific date, and there was no section for identifying restraints being utilized.

c) Inspector #603 reviewed the home's policy titled "Restraints" dated February, 2016, which indicated that "Every use of a physical device to restrain a resident is to be documented and is to include the following documentation: the circumstances precipitating the application of the physical device; the alternatives considered and why not appropriate; any instructions relating to the restraint order; and all assessments and reassessments".

Inspector #603 reviewed resident #003, #005, and #006's health care records and none of these health records included the above information. The ADOC confirmed this lack of documentation for resident #003, #005, and #006. [s. 8. (1) (b)]

2. During a review of resident #004's electronic health care record, Inspector #575 noted that there was no weight recorded during a specific month. The Inspector also noted that the resident had a 27.9 per cent weight gain (18.1 kilograms (kgs) in a two month period, with weights recorded as 64.8 kgs and 82.9 kgs respectively.

During an interview with the Inspector, RN #104 stated that PSWs recorded residents' weights in the "TPR book", and registered staff then entered the weights into Point Click Care (PCC). If the registered staff noticed a weight discrepancy, they were to instruct the PSWs to re-weigh the resident. The RN stated that the resident was re-weighed on a certain date at 82.1 kgs, however, it was not entered into PCC. The RN confirmed that there was no weight recorded for this resident for a specific month.

During an interview with the ADOC, they stated to the Inspector that when a resident was re-weighed, registered staff were to enter the new weight into PCC.

The home's policy titled, "Weighing Residents CN-W-02-1", last revised May 2016, indicated that all resident's should be weighed by PSWs on the first bath day of the month, and registered staff are to record the weight into the electronic software within the first 10 days of the month. Resident's with a significant weight change will be re-weighed and the re-weigh recorded. [s. 8. (1) (b)]

3. a) During a review of resident #002's electronic health care record, Inspector #575 noted that there was no weight recorded during a specific month. The Inspector also noted that the resident had a 10.3 per cent weight loss (6.1 kgs) in a five month period, with weights recorded as 59.5 kgs and 53.4 kgs respectively and a 10.9 per cent weight loss (6.7 kgs) in another five month period, with weights recorded as 61.5 kgs and 54.8 kgs respectively.

During an interview with the Inspector, RN #104 confirmed that there was no weight recorded for this resident for the specific month and that there was no re-weigh for this resident in two other specific months.

During an interview with the Registered Dietitian (RD), they stated that they were following the resident; however, referrals were not received for those two specific months, regarding the weight changes over the six month periods.

The home's policy titled, "Weighing Residents CN-W-02-1", last revised May 2016, indicated that all resident's should be weighed by PSW's on the first bath day of the month, and registered staff were to record the weight into the electronic software within the first ten days of the month. Resident's with a significant weight change would be re-weighed and the re-weigh recorded. Significant weight changes were described as: 5 per cent or more in one month, 7.5% or more in three months, 10% or more in six months, and any other weight change that compromises the resident's health status. If the change in weight is confirmed as significant, staff are to complete a referral to the Registered Dietitian.

b) Inspector #575 reviewed the resident #002's 'Nutritional Intake Record' for one week. The inspector noted the following missing entries:

There were six times at 1000 hours, once at 1200 hours, five times at 1400 hours,

and once at 1700 hours, that there was no entry for nourishment.

During an interview with the Inspector, PSW #112 stated that staff were to complete the Nutritional Intake Record for each nourishment and meal each shift. The PSW confirmed there were missing entries on resident #002's Nutritional Intake Record.

The home's policy titled, "Documentation - HCA/PSW Resident Care Flow Sheet CN-D-19-1", no date, stated that PSW's must document intake of food and fluid for all meals and snacks on the Nutritional Flow Chart on each shift. [s. 8. (1) (b)]

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 #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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition was reassessed and the effectiveness of the restraining was evaluated by a physician or 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 based on the resident's condition or circumstances.

During the inspection, Inspector #603 observed resident #003 sitting in a specific wheelchair with an assistive device applied.

Inspector #603 reviewed resident #003's care plan which revealed a focus for "Restraints". The interventions included that staff were to: apply the assistive device when the resident was up in their wheelchair; check the resident and release the device as per facility protocol; check the resident hourly and release the device every two hours.

Inspector #603 reviewed resident #003's "Restraint Flow Sheet" for a ten day period, and out of the ten days, there were seven days with no RN/RPN signature for assessments on days (0800-1500 hours), and six days with no RN/RPN signature for assessments on evenings (1600-2300 hours).

Inspector #603 interviewed the ADOC who confirmed the lack of documentation and explained that if there was no signature from an RN/RPN on the "Restraint Flow Sheet", this meant that the RN/RPN's eight hours assessments were not completed.

Inspector #603 reviewed the home's policy titled "Restraints" dated February 2016, which indicated that the following requirements were to be applied if a resident was physically restrained: "The resident's condition will be 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. Registered staff are to document the reassessment and effectiveness of restraints on the restraint/PASD with restraining properties flow sheet'. [s. 110. (2) 6.]

2. During the inspection, Inspector #603 observed resident #006 sitting in a specific

wheelchair.

Inspector #603 reviewed the resident's care plan which indicated a focus for "Physical Restraint Use FFSB and tilt chair". The interventions included that staff were to: apply the assistive device when the resident was up in their wheelchair; check the resident and release the device as per facility protocol; check the resident hourly and release the device every two hours.

Inspector #603 reviewed resident #006's "Restraint Flow Sheet" for a ten day period, and out of the ten days, there were seven days with no RN/RPN signature for assessments on days (0800-1500 hours), and six days with no RN/RPN signature for assessments on evenings (1600-2300 hours). [s. 110. (2) 6.]

3. On a certain date, Inspector #603 observed resident #005 sitting in a wheelchair with an assistive device applied.

Inspector #603 reviewed the resident's care plan which indicated a focus for "Physical Restraint Use FFSB". The interventions included that staff were to: apply the assistive device when the resident was up in their wheelchair; check the resident and release the device as per facility protocol; check the resident hourly and release the device every two hours. Inspector also noted a "Restraint Flow Sheet" for resident #005, which identified the assistive device as a restraint, and the staff had been documenting hourly checks for the restraint.

Inspector #603 reviewed resident #005's "Restraint Flow Sheet" for a ten day period, and out of the ten days, there were seven days with no RN/RPN signature for assessments on days (0800-1500 hours), and six days with no RN/RPN signature for assessments on evenings (1600-2300 hours). [s. 110. (2) 6.]

Additional Required Actions:

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

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents received the annual training on the home's policy to minimize the restraining of residents.

During the inspection, Inspector #603 observed resident #003 sitting in a specific wheelchair with an assistive device, resident #005 sitting in a wheelchair with an assistive device, and resident #006 sitting in a specific wheelchair.

Inspector #603 interviewed the Administrator who explained that the home had provided the annual training on the home's "Restraints" policy, to all staff who provided direct care to residents in 2015. However, the Administrator could not find documentation and agreed with Inspector #603 that they could not confirm that all staff had received the annual training.

Inspector #603 reviewed the home's policy titled "Restraints" dated February 2016, which indicated that all staff and volunteers would review the home's Restraint and PASD policy as part of an annual review. [s. 221. (2) 1.]

Additional Required Actions:

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

(A1)The following order(s) have been rescinded:CO# 006

(A1) 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 all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1 Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76(7) of the Act, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O.

Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises their health status.

During a review of resident #001's electronic health care record, Inspector #575 noted that the resident had a 21 per cent weight loss (18.7 kilograms (kgs) over a 2 month period, with weights recorded as 88.9 kgs and 70.2 kgs respectively. In

addition, the resident had an 8.2 per cent weight loss (7.8 kgs) for a different month, with weights recorded as 94.9 kgs and 87.1 kgs respectively.

During an interview with the Inspector #575, RN #104 stated that they have until the tenth of the month to enter residents' weights into the electronic plan of care (Point Click Care (PCC)). The Inspector asked the RN to explain the process when there was a discrepancy in weight and what the parameters were to determine a significant change. The RN stated that they would instruct the PSWs to re-weigh the resident if there was a difference of 5 kgs; however, they typically worked night shift and were unsure what the other RNs would do. If the significant change was confirmed, registered staff were to complete a referral to the Registered Dietitian (RD). The RN confirmed that there was no re-weigh or referral to the RD completed at that time for resident #001's documented weight losses.

During an interview with the RD, they confirmed that they did not receive a referral for the weight loss identified above. The RD stated that the resident was re-weighed on a specific date, at 72.7 kgs which was recorded in the "TPR book", however, the re-weigh was not entered into PCC. The RD stated that the re-weigh confirmed a significant loss and they would have expected to receive a referral, however this did not always happen.

During an interview with the ADOC, they stated to Inspector #575 that when a resident was re-weighed, registered staff were to enter the new weight into PCC.

The home's policy titled, "Weighing Residents CN-W-02-1", last revised May 2016, indicated that all resident's should be weighed by PSW's on the first bath day of the month, and registered staff are to record the weight into the electronic software within the first ten days of the month. Resident's with a significant weight change will be re-weighed and the re-weigh recorded. Significant weight changes were described as: 5 per cent or more in one month, 7.5% or more in three months, 10% or more in six months, and any other weight change that compromises the resident's health status. If the change in weight is confirmed as significant, staff are to complete a referral to the RD. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents with the following weight changes will be assessed using an interdisciplinary approach, and that actions will be taken and outcomes evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises their health status., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis.

During the inspection, Inspector #603 interviewed the Administrator who explained that there were no formal analysis of the restraining of residents undertaken on a monthly basis. The Administrator explained that on a monthly basis, they printed a list of residents who were restrained and gave this list to the registered staff, who then reviewed the requirements and the current flow sheets. There were no formal process and no documentation kept around these discussions.

Inspector reviewed the home's policy titled "Restraints" dated February 2016, which indicated: "On a monthly basis, the home will conduct an analysis of the restraining of residents by use of a physical device or pursuant to the common law duty. Indicators to be considered (but not limited to):
1. The number of residents to whom physical restraints have been applied, compared to the total number of residents.
2. The number of residents to whom restraints under common law have been applied, compared to the total number of residents.
3. The change from the last, in the number and percentage of residents to whom restrains have been applied.
4. The results of the monthly analyses will be incorporated into the annual review and evaluation of the restraint reduction program as part of the home's quality improvement/risk management program to determine the effectiveness of the policy. [s. 113. (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 ensuring that an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to take action in response to the incident, including the outcome of the incident.

Inspector #603 reviewed a Critical Incident Report (CI) report submitted to the Director on a specific date. The CI related to the home's respiratory outbreak declared on the same day. Upon a further review of the CI report, Inspector #603 noted that there was no report to the Director as to when the respiratory outbreak was over.

Inspector #603 reviewed the "Timiskaming Public Health Report for the home's Outbreak #2263-2015-010" which indicated that the home's respiratory outbreak was declared on a certain date and over, ten days later. The respiratory outbreak totalled eleven days in duration.

Inspector #603 interviewed the Administrator who confirmed that the home failed to report the respiratory outbreak over. [s. 107. (4) 3.]

Issued on this 6 day of December 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

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159 Cedar Street, Suite 403
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SARAH CHARETTE (612) - (A1)

Inspection No. / No de l'inspection : 2016_391603_0019 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 011645-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Dec 06, 2016;(A1)

Licensee / Titulaire de permis :
675412 ONTARIO INC
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

LTC Home / Foyer de SLD :
NORTHVIEW NURSING HOME
77 RIVER ROAD, P.O. BOX 1139, ENGLEHART, ON, P0J-1H0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Tracey Gemmill

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

To 675412 ONTARIO INC, 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)

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall:
1. Ensure that all staff who provide direct care to residents have convenient and immediate access to the care plan.
2. Review and revise all resident care plans and kardexes to ensure that they set out clear directions to all front line staff and others who provide direct care to residents.
3. Educate and retrain all nursing staff regarding the importance of updating and communicating clear directions to staff and others who provide direct care to residents in order to ensure the resident's health, safety, and well being.
4. Develop and implement an auditing process which will identify care plans that do not set out clear directions so that corrections can be made.

Grounds / Motifs :

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

During the inspection, it was determined that resident #001 had a weight loss of five

per cent or more in a one month period. Inspector #575 reviewed the resident's electronic care plan in Point Click Care (PCC) and under the focus of communication problem and endocrine system, there were no interventions. Under the focus activities of daily living, the interventions related to eating stated the following: Eating: resident is able to (specify: hold cup, feed self, eat finger foods independently), therefore, it was incomplete.

Inspector #603 interviewed the ADOC who explained that only RNs and RPNs have access to the electronic care plan. The PSWs review the kardex or the paper care plan in the resident's chart as needed. The kardex only had interventions and not the complete care plan.

Inspector #575 reviewed resident #001's kardex and paper care plan. The Inspector noted that the kardex was printed in October 2015 . The Nutrition Risk identified that the resident had a certain body mass index (BMI) in April 2015, with no change in weight within the past six months to a year. The paper care plan did not include a date and indicated that the resident had difficulty chewing harder textured foods.

Inspector #575 interviewed the Administrator regarding the plans of care. The Inspector showed the Administrator the kardex printed. The Administrator confirmed that PSWs reviewed the kardex as a quick reference and that the kardex was printed from the previous electronic system (Med e-care). The Administrator also confirmed that they were still in the process of switching over information into the plans of care from Med-e-care to PCC. The Inspector showed the Administrator the resident's current electronic care plan from PCC. The Administrator confirmed that the kardex was not the most recent and that the PCC care plan was not up to date.

During an interview with Inspector #575, RN #110 stated that they were not sure how often or who updated the kardexes.

Inspector #575 interviewed PSW #108 and #109 regarding how they are provided directions on the type of care a resident required. They stated that they would review the kardex; however, they were rarely up to date. They stated that they used to look at the paper care plan in the resident's chart when they were located at the nursing station; however, they were now located in the doctor's room and they rarely go in this room. PSW #108 stated that it is difficult because depending on what RN was working, they will direct care differently. Due to the kardex not being up to date and depending on what RN was working, they do not have clear directions on what type

of care is required for residents. (575)

2. During the inspection, Inspector #603 observed resident #005 sitting in a wheelchair with an assistive device. Resident #005 explained that they wanted the assistive device in place. Resident #005 also explained that they were able to apply and remove the assistive device as needed, and demonstrated that they could.

Inspector #603 reviewed resident #005's health care record which identified a physician order for a Personal Assistance Service Device (PASD) consisting of the above assistive device to be applied, while the resident was in their wheelchair.

Inspector #603 reviewed the resident's care plan which indicated a focus for "Physical Restraint Use FFSB". The interventions included that staff were to: apply the assistive device when the resident was up in their wheelchair, check the resident and release the device as per facility protocol; check the resident hourly and release the device every two hours. Inspector #603 also noted a "Restraint Flow Sheet" for resident #005, which identified the assistive device as a restraint, and the staff had documented hourly checks for the restraint.

LTCHA, 2007 S.O. 2007, s. 6. (1) (c) was issued previously as VPC during Inspection #2015_380593_0018, VPC during Inspection #2014_336580_0026, VPC during Inspection #2014_140158_0005, and VPC during Inspection #2013_140158_0038.

The decision to issue this compliance order was based on the scope which was isolated, the severity which indicated a potential for actual harm and the compliance history which despite 4 previous VPCs, NC continues with this area of the legislation. (603)

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

Dec 31, 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)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee shall develop and implement a process to ensure that all residents who require a Personal Assistance Service Device (PASD) or a restraint receive a comprehensive and formal assessment that includes the resident's needs and preferences.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

On a certain date, at 1018 hours, Inspector #603 observed resident #006 sitting in a specific wheelchair. At 1245 hours, Inspector #603 observed resident #006 sitting in a wheelchair with an assistive device applied.

Inspector #603 reviewed the resident's care plan which indicated a focus for "Physical Restraint Use FFSB and tilt chair". The interventions included that the assistive device was to be applied when the resident was in their wheelchair, and if the wheelchair was in a certain position, staff were to remove the assistive device.

Inspector #603 reviewed resident #006's health care record which did not identify an assessment of the resident need for restraints.

Inspector #603 interviewed RN #104 who did not find any assessment for restraints completed and could not explain how the decision was made to apply the restraints.

Inspector #603 interviewed the ADOC who confirmed that there was no assessment completed on resident #006 to determine the need for a restraint. (603)

2. During the inspection, Inspector #603 observed resident #003 sitting in a specific wheelchair with an assistive device applied.

Inspector #603 interviewed the ADOC who explained that resident #003 required the assistive device and a specific wheelchair to prevent them from reaching out and falling out of their wheelchair. The ADOC confirmed that the resident was not capable of removing the assistive device and for this reason, both the assistive device and the specific wheelchair were considered restraints.

Inspector #603 reviewed resident #003's care plan which indicated a focus for "Restraints" and the interventions included the assistive device and a specific wheelchair to maintain safety, and to prevent entrapment and bodily injury. Inspector #603 also reviewed the resident's health care record which did not include any assessment regarding the resident's needs for restraints; however, there was a "Restraint/PASD and Alternative Assessment" form which indicated that it "must be completed prior to initial restraint/PASD application, minimum quarterly and with change in condition that impacts use of restraint/PASD". This form was not completed.

Inspector interviewed the ADOC who confirmed that there was no assessment completed to determine the need for an assistive device or the specific wheelchair (restraints) and the "Restraint/PASD and Alternative Assessment" form was not completed.

Inspector #603 reviewed the home's policy titled: "Restraints (CN-R-05-1), dated February, 2016". The policy indicated: "Every use of a physical device to restrain a resident is documented and includes the circumstances precipitating the application of the physical device; what alternatives were considered and why those alternatives were inappropriate; all assessments and reassessments, including the resident's responses. (603)

3. During the inspection, Inspector #603 observed resident #005 sitting in a wheelchair with an assistive device. Resident #005 explained that they wanted the assistive device in place. Resident #005 also explained that they were able to apply and remove the assistive device as needed, and demonstrated that they could.

Inspector #603 reviewed resident #005's health care record which identified a physician order for a Personal Assistance Service Device (PASD) consisting of the above assistive device to be applied, while the resident was in their wheelchair.

Inspector #603 reviewed the resident's care plan which indicated a focus for "Physical Restraint Use FFSB". The interventions included that staff were to: apply the assistive device when the resident was up in their wheelchair, check the resident and release the device as per facility protocol; check the resident hourly and release the device every two hours. Inspector #603 also noted a "Restraint Flow Sheet" for resident #005, which identified the assistive device as a restraint, and the staff had documented hourly checks for the restraint.

According to the LTCHA 2007, 30. (1) (2), The use of a physical device from which a resident is both physically and cognitively able to release themself is not a restraining of the resident.

Inspector #603 interviewed PSW #107 who explained that resident #005 did not have a restraint. The assistive device was used to help the resident with positioning and the resident was capable of applying and removing the assistive device as needed. PSW #107 could not explain why the staff were documenting on the restraint flow sheet and later explained that they had brought this issue forward to management and nothing had been changed.

Although there was no previous compliance history related to this provision, there have been other non-compliances including but not limited to the area of care planning.

The decision to issue this compliance order was based on the scope which was widespread and the severity which indicated a potential for actual harm.
(603)

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

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

Dec 31, 2016(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
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.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

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

The licensee shall ensure that all residents with a physical restraint have an order given by the physician or the registered nurse in the extended class.

Grounds / Motifs :

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

On a certain date, at 1018 hours, Inspector #603 observed resident #006 sitting in a specific wheelchair. At 1245 hours, Inspector #603 observed resident #006 sitting in a wheelchair with an assistive device applied.

Inspector #603 interviewed RN #104 who explained that resident #006 required the assistive device and or a specific wheelchair to prevent the resident from falling out of their wheelchair.

Inspector #603 reviewed resident #006's health care record which revealed no order by the physician or the registered nurse in the extended class for the assistive device or a specific wheelchair as restraints.

Inspector #603 interviewed the ADOC who confirmed that there was no order for the assistive device and/or a specific wheelchair as a form of restraints. (603)

2. During the inspection, Inspector #603 observed resident #003 sitting in a specific wheelchair with an assistive device applied.

Inspector #603 interviewed RN #104 who explained that resident #003 required an assistive device and a specific wheelchair to prevent them from reaching out and falling. The Inspector also interviewed the ADOC who confirmed that resident #003 required two physical restraints: a specific assistive device and a specific wheelchair. The ADOC also confirmed that resident #003 was not able to remove the assistive device on their own.

Inspector #603 reviewed resident #003's care plan which revealed a focus for "Restraints", which indicated that resident #003 required the assistive device on their wheelchair for a specific reason and at times required their wheelchair in a certain position, to prevent certain movements.

Inspector #603 reviewed resident #003's health care record which did not include a physician or a registered nurse in the extended class order for the assistive device and or the specific wheelchair as a restraint.

An interview with the ADOC confirmed that there was no physician or registered nurse in the extended class order for the two physical restraints.

Inspector #603 reviewed the home's policy titled "Restraint #CN-R-05-4", which indicated that prior to physical restraint use, a physician or registered nurse in the extended class must order a restraint. The order must clearly indicate the type of restraint, when and where it is to be used, the detailed reason for use and any special instructions for use. The order must be included in the care plan.

LTCHA, 2007 S.O. 2007, s. 31. (2) 4. was issued previously as WN during Inspection #2015_380593_0018.

The decision to issue this compliance order was based on the scope which was a pattern, the severity which indicated a potential for actual harm and the compliance history which despite a previous WN, NC continues with this area of the legislation. (603)

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

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

Dec 31, 2016(A1)

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall review and re-educate all staff and others who provide direct care to the residents on the home's written "Restraints", "Weighing Residents", and "Documentation - HCA/PSW Resident Care Flow Sheet" policies. Once completed, the home must ensure that these policies are complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) During a review of resident #002's electronic health care record, Inspector #575 noted that there was no weight recorded during a specific month. The Inspector also noted that the resident had a 10.3 per cent weight loss (6.1 kgs) in a five month period, with weights recorded as 59.5 kgs and 53.4 kgs respectively and a 10.9 per cent weight loss (6.7 kgs) in another five month period, with weights recorded as 61.5 kgs and 54.8 kgs respectively.

During an interview with the Inspector, RN #104 confirmed that there was no weight recorded for this resident for the specific month and that there was no re-weigh for this resident in two other specific months.

During an interview with the Registered Dietitian (RD), they stated that they were following the resident; however, referrals were not received for those two specific months, regarding the weight changes over the six month periods.

The home's policy titled, "Weighing Residents CN-W-02-1", last revised May 2016, indicated that all resident's should be weighed by PSW's on the first bath day of the month, and registered staff were to record the weight into the electronic software within the first ten days of the month. Resident's with a significant weight change would be re-weighed and the re-weigh recorded. Significant weight changes were described as: 5 per cent or more in one month, 7.5% or more in three months, 10% or more in six months, and any other weight change that compromises the resident's health status. If the change in weight is confirmed as significant, staff are to complete a referral to the Registered Dietitian.

b) Inspector #575 reviewed the resident #002's 'Nutritional Intake Record' for one week. The inspector noted the following missing entries:

There were six times at 1000 hours, once at 1200 hours, five times at 1400 hours, and once at 1700 hours, that there was no entry for nourishment.

During an interview with the Inspector, PSW #112 stated that staff were to complete the Nutritional Intake Record for each nourishment and meal each shift. The PSW confirmed there were missing entries on resident #002's Nutritional Intake Record.

The home's policy titled, "Documentation - HCA/PSW Resident Care Flow Sheet CN-D-19-1", no date, stated that PSW's must document intake of food and fluid for all meals and snacks on the Nutritional Flow Chart on each shift.

(603)

2. During a review of resident #004's electronic health care record, Inspector #575 noted that there was no weight recorded during a specific month. The Inspector also noted that the resident had a 27.9 per cent weight gain (18.1 kilograms (kgs) in a two month period, with weights recorded as 64.8 kgs and 82.9 kgs respectively.

During an interview with the Inspector, RN #104 stated that PSWs recorded residents' weights in the "TPR book", and registered staff then entered the weights into Point Click Care (PCC). If the registered staff noticed a weight discrepancy, they were to instruct the PSWs to re-weigh the resident. The RN stated that the resident was re-weighed on a certain date at 82.1 kgs, however, it was not entered into PCC. The RN confirmed that there was no weight recorded for this resident for a specific month.

During an interview with the ADOC, they stated to the Inspector that when a resident was re-weighed, registered staff were to enter the new weight into PCC.

The home's policy titled, "Weighing Residents CN-W-02-1", last revised May 2016, indicated that all resident's should be weighed by PSWs on the first bath day of the month, and registered staff are to record the weight into the electronic software within the first 10 days of the month. Resident's with a significant weight change will be re-weighed and the re-weigh recorded. (603)

3. a) Inspector #603 reviewed the home's policy titled "Restraints" dated February, 2016, which indicated the permitted physical restraints used in the home. These included: seat belts, table tops, and side rails. There was no mention of tilted wheelchairs as a permitted physical restraint. Furthermore, the policy indicated "Failure to follow the policy and misuse of restraints constituted abuse".

During the inspection, Inspector #603 observed numerous times, two different residents tilted in wheelchairs.

Inspector #603 interviewed the Administrator who explained that tilted wheelchairs were not considered a restraint as per the home's restraint policy; however, the front line staff were using tilted wheelchairs as physical restraints for different residents.

b) Inspector #603 reviewed the home's policy titled "Restraints" dated February, 2016, which indicated that "All appropriate staff are to be aware at all times of when a resident is being restrained by use of a physical device. Staff are to be notified at the change of shift report of residents who are being restrained by use of a physical device or PASD with restraining properties".

During the inspection, Inspector #603 interviewed PSW #112 who explained that they had received report that morning and there was no discussion about restrained residents. PSW #112 further explained that at shift report, there was never a report on which resident was restrained unless there was a new intervention or a change to a restraint.

Inspector #603 interviewed the Administrator who explained that the home's expectation was that only if a new restraint is identified or there has been a change to a restraint will the staff discuss restraints at shift report. The Administrator further explained that "the only exception of a new restraint would be communicated and the restraints would not be documented on the shift report".

Inspector #603 reviewed the shift report for a specific date, and there was no section for identifying restraints being utilized.

c) Inspector #603 reviewed the home's policy titled "Restraints" dated February, 2016, which indicated that "Every use of a physical device to restrain a resident is to be documented and is to include the following documentation: the circumstances precipitating the application of the physical device; the alternatives considered and why not appropriate; any instructions relating to the restraint order; and all assessments and reassessments".

Inspector #603 reviewed resident #003, #005, and #006's health care records and none of these health records included the above information. The ADOC confirmed this lack of documentation for resident #003, #005, and #006.

LTCHA, 2007 S.O. 2007, r. 8. (1) (b) was issued previously as WN during Inspection

#2014_336580_0025.

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicated a potential for actual harm and the compliance history which despite WNs, NC continues with this area of the legislation.

(603)

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

Dec 31, 2016(A1)

Order # /
Ordre no : 005

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

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 ensure that the resident's condition is reassessed and the effectiveness of the restraining is evaluated by a physician or 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 based on the resident's condition or circumstances.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's condition was reassessed and the effectiveness of the restraining was evaluated by a physician or 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 based on the resident's condition or circumstances.

On a certain date, Inspector #603 observed resident #005 sitting in a wheelchair with an assistive device applied.

Inspector #603 reviewed the resident's care plan which indicated a focus for "Physical Restraint Use FFSB". The interventions included that staff were to: apply the assistive device when the resident was up in their wheelchair; check the resident and release the device as per facility protocol; check the resident hourly and release the device every two hours. Inspector also noted a "Restraint Flow Sheet" for resident #005, which identified the assistive device as a restraint, and the staff had been documenting hourly checks for the restraint.

Inspector #603 reviewed resident #005's "Restraint Flow Sheet" for a ten day period, and out of the ten days, there were seven days with no RN/RPN signature for assessments on days (0800-1500 hours), and six days with no RN/RPN signature for assessments on evenings (1600-2300 hours). (603)

2. During the inspection, Inspector #603 observed resident #006 sitting in a specific wheelchair.

Inspector #603 reviewed the resident's care plan which indicated a focus for "Physical Restraint Use FFSB and tilt chair". The interventions included that staff were to: apply the assistive device when the resident was up in their wheelchair; check the resident and release the device as per facility protocol; check the resident hourly and release the device every two hours.

Inspector #603 reviewed resident #006's "Restraint Flow Sheet" for a ten day period, and out of the ten days, there were seven days with no RN/RPN signature for assessments on days (0800-1500 hours), and six days with no RN/RPN signature for assessments on evenings (1600-2300 hours). (603)

3. During the inspection, Inspector #603 observed resident #003 sitting in a specific wheelchair with an assistive device applied.

Inspector #603 reviewed resident #003's care plan which revealed a focus for "Restraints". The interventions included that staff were to: apply the assistive device when the resident was up in their wheelchair; check the resident and release the device as per facility protocol; check the resident hourly and release the device every two hours.

Inspector #603 reviewed resident #003's "Restraint Flow Sheet" for a ten day period, and out of the ten days, there were seven days with no RN/RPN signature for assessments on days (0800-1500 hours), and six days with no RN/RPN signature for assessments on evenings (1600-2300 hours).

Inspector #603 interviewed the ADOC who confirmed the lack of documentation and explained that if there was no signature from an RN/RPN on the "Restraint Flow Sheet", this meant that the RN/RPN's eight hours assessments were not completed.

Inspector #603 reviewed the home's policy titled "Restraints" dated February 2016, which indicated that the following requirements were to be applied if a resident was physically restrained: "The resident's condition will be 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. Registered staff are to document the reassessment and effectiveness of restraints on the restraint/PASD with restraining properties flow sheet'.

Although there was no previous compliance history related to this provision, there have been other unrelated non-compliances.

The decision to issue this compliance order was based on the scope which was widespread and the severity which indicated a potential for actual harm. (603)

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

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

Dec 31, 2016(A1)

(A1)
The following Order has been rescinded:

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

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

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

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 6 day of December 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAH CHARETTE - (A1)

Service Area Office /
Bureau régional de services : Sudbury