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 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 14, 2019	2019_575214_0013	003913-18	Complaint

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

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

R. H. Lawson Eventide Home
5050 Jepson Street NIAGARA FALLS ON L2E 1K5

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

CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 17, 18, 23, 2019.

Please note: This inspection was conducted simultaneously with Critical Incident inspection 2019_575214_0014 / 033742-18.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED); Director of Care (DOC); Nurse Manager; Registered staff and Personal Support Workers (PSW's).

During the course of the inspection, the inspector reviewed the complaint; relevant electronic mail (email) documents; relevant training documents; relevant policy and procedures; resident clinical records; and observed residents.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

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

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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

Findings/Faits saillants :

1. The licensee failed to ensure that no prohibited restraint devices, that limit movement, were used in the home.

A review of complaint log #003913-18, indicated that an identified staff member had applied an identified device on residents, against their plan of care.

The DOC provided an email document dated with a specified date and time, that had been sent from an identified person to the DOC. The email indicated that an identified person had observed resident #002 to have an identified device applied and had showed the resident in this manner, to an identified staff member.

The DOC provided a second email document dated two days later, that had been sent from an identified person to the DOC. The email indicated that the identified person had witnessed the previous evening, resident #002, to have demonstrated a specified responsive behaviour. The email indicated that an identified staff member was in the process of applying an identified device to the resident and was informed not to.

During an interview with an identified person on a specified date, it was indicated that they had been informed that resident #002 had an identified device applied. The

identified person indicated that this was observed by them and reported to the DOC.

The identified person also confirmed the information in the email that they had sent to the DOC two days later, in which an identified staff member was in the process of applying an identified device to the resident and was informed not to.

During an interview with a second identified person, they indicated that they could not recall the date; however, had observed resident #002 with an identified device in place and reported this to an identified staff member immediately. The identified person indicated that since this date, they had not observed any resident to have this identified device in place.

During an interview with an identified staff member, they indicated they recalled on two occasions, resident #002 to be demonstrating specified responsive behaviours. The staff member indicated they had attempted specified interventions with no success. The staff member indicated on one occasion, they applied an identified device for safety and on a second occasion, were going to apply the identified device and were informed not to. The identified staff member indicated that they had received specified education and training prior to this incident and again after.

During an interview with the DOC on a specified date, they indicated that the above incident was addressed on or about one day after becoming aware and that it was confirmed that resident #002 had an identified device applied.

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 no prohibited restraint devices, that limit movement, are used in the home, to be implemented voluntarily.

WN #2: 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 failed to ensure 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 was undertaken on a monthly basis.

A review of complaint log #003913-18, indicated that an identified staff member had applied an identified device on residents, against their plan of care.

During an interview with the DOC on a specified date, they indicated that the home had an identified committee that reviewed residents who used specified devices; however, not every resident who used the specified device, had been reviewed or analyzed on a monthly basis. [s. 113. (a)]

2. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

A review of complaint log #003913-18, indicated that an identified staff member had applied an identified device on residents, against their plan of care.

During an interview with the DOC on a specified date, they confirmed that an identified policy of the home had not been evaluated yearly and was last evaluated in an identified month in 2017. [s. 113. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 and to ensure 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A review of complaint log #003913-18, indicated that an identified staff member had applied an identified device on residents, against their plan of care.

A review of the licensee's policy, titled, "Resident Abuse" (dated September 12, 2017), indicated the following:

Under definitions of abuse: the use of prohibited restraints.

Prohibited devices used to restrain a resident, were identified in the licensee's "Restraint and Personal Assistive Service Devices (PASD) policy, dated with a revision date of December 19, 2017, and indicated that a specific item must not be used in the home.

Under "Reporting Requirements": any person who witnesses a resident being abused must intercede and stop the abuse to prevent any further harm. Person witnessing the abuse is to report it, at once, to the Ministry of Health and Long Term Care (MOHLTC) and Registered Staff and complete a written account of the incident which is then given to the Administrator or designate immediately following the incident.

The DOC provided an email document dated with a specified date and time, that had been sent from an identified person to the DOC. The email indicated that an identified person had observed resident #002 to have an identified device applied and had showed the resident in this manner, to an identified staff member.

The DOC provided a second email document dated two days later, that had been sent from an identified person to the DOC. The email indicated that the identified person had witnessed the previous evening, resident #002, to have demonstrated a specified responsive behaviour. The email indicated that an identified staff member was in the process of applying an identified device to the resident and was informed not to.

During an interview with an identified person on a specified date, it was indicated that they had been informed that resident #002 had an identified device applied. The identified person indicated that this was observed by them and reported to the DOC.

The identified person also confirmed the information in the email that they had sent to the DOC two days later, in which an identified staff member was in the process of applying an identified device to the resident and was informed not to.

During an interview with a second identified person, they indicated that they could not recall the date; however, had observed resident #002 with an identified device in place and reported this to an identified staff member immediately. The identified person indicated that since this date, they had not observed any resident to have this identified device in place.

During an interview with an identified staff member, they indicated they recalled on two occasions, resident #002 to be demonstrating specified responsive behaviours. The staff member indicated they had attempted specified interventions with no success. The staff

member indicated on one occasion, they applied an identified device for safety and on a second occasion, were going to apply the identified device and were informed not to. The identified staff member indicated that they had received specified education and training prior to this incident and again after.

During an interview with the DOC on a specified date, they indicated that the above incident was addressed on or about one day after becoming aware and that it was confirmed that resident #002 had an identified device applied.

The DOC indicated that they had not reported this alleged incident to the MOHLTC as they felt that an identified person had acted immediately and informed the identified staff member that applying an identified device to the resident in this manner had not been acceptable. The DOC indicated that the identified staff member had also been provided education and re-training in regards to the applicable, licensee's programs. The ED and DOC confirmed that in regards to resident #002, the home had not complied with their policy to promote zero tolerance of abuse and neglect. [s. 20. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of complaint log #003913-18, indicated that an identified staff member had applied an identified device on residents, against their plan of care.

During an inspection at the home, it had been identified through review of emails and interviews with staff, that resident #002 had an identified device applied on a specified date.

A review of the resident's progress notes for an identified period of three days, had not identified any documentation in relation to this incident, including any assessments completed or the resident's response in relation to the incident.

During an interview with the DOC on an identified date, they confirmed that actions taken with respect to resident #002, in relation to this incident, including the resident's response to the incident, had not been documented. [s. 30. (2)]

Issued on this 17th day of May, 2019

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

Original report signed by the inspector.