Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 7, 2013	2013_168202_0013	T-1798-12, T-95-13	Follow up

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE, MISSISSAUGA, ON, L5H-2S6

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

RIVER GLEN HAVEN NURSING HOME
160 High Street, P.O. Box 368, Sutton West, ON, L0E-1R0

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

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 26, 28, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care, Acting Assistant Director of Care, Environmental Services Supervisor, Physiotherapy Assistant, Registered Nursing Staff, Personal Support Workers, Housekeeping Staff

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, observed the use and application of physical restraints,observed resident washroom equipment, reviewed the home's policies related to restraint use, reviewed staff education records on restraint application and use

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Minimizing of Restraining

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that staff apply all seat belt restraints used in the home in accordance with any manufacturer's instructions and that the seat belt restraints used are well maintained. [s.110.(1)(2)]

A review of the manufacturer's instructions by 'Body Point' for application of seat belt restraints used in the home, titled 'The Hip Belt User's Guide by Body Point' states, 'keep belt tightened at adjustment straps during fitting and daily use to ensure correct placement. The manufacturer's instructions include a picture of a person wearing a seat belt securely fit between thigh and pelvis with directions to ensure the proper fit. The illustration indicates that the position of a hip belt is fitted by using the A.S.I.S (Anterior Superior Iliac Spine) as a key orientation and the belt is used to maintain the hip at 100 degrees, knees 105 degrees and ankles 90 degrees. An interview with the Acting Director of Care (ADOC) revealed that staff are also directed to use the seat belt application instructions provided by 'Motion Specialties', titled 'Use of Pelvic Belts in Wheelchairs' which states "close belt and tighten until it is snug across the lower pelvis or thighs".

On February 26 and 28, 2013 during the course of inspection the following was observed:
-Resident #001 was observed to be reclined in a Broda wheelchair with seat belt restraint positioned loose and resting on mid-thigh. An identified Personal Support Worker (PSW) indicated in an interview that resident #001's restraint seat belt was loose and not in proper position. The (PSW) attempted to adjust resident #001's seat belt restraint, however the seat belt could not be adjusted due to the poor condition and inappropriate length. Staff interviews revealed that resident #001 has been found to slump to the side of his/her wheelchair and fall down into the side of the chair.
-Resident #002 was observed to be sitting in his/her wheelchair with a seat belt restraint positioned loosely between mid and upper thigh. An identified (PSW) confirmed that resident #002's seat belt restraint was applied too loose and has been identified to slide forward in his/her wheelchair.
-Resident #004 was observed to be sitting in his/her wheelchair with the seat belt restraint positioned loose and positioned between mid and upper thigh. The (ADOC) confirmed that resident #004's seat belt restraint had been applied too loose and was in incorrect position.
-Resident #005 was observed to be reclined in a Broda wheelchair with a seat belt restraint applied loose and resting along mid thigh. Staff interviews revealed that resident #005 will often slide down out of his/her Broda Chair requiring repositioning

with the assistance of two staff to position his/her back up in the chair. The (ADOC) confirmed that resident #005's seat belt restraint was applied too loose and in an incorrect position. The (ADOC) attempted to adjust the seat belt, however the seat belt was not able to be adjusted due to the length of the seat belt.
An interview with an identified (PSW) revealed that he/she has never tightened or loosened any resident's restraint seat belt because he/she is not aware of any manufacturer's instructions and confirmed that he/she will only apply the seat belt in the condition and position as found in the wheelchair. Staff interviews indicated that most of the seat belt restraints in the home are unable to be adjusted due to the length of the seat belt and/or soiled condition of the adjustment clasps which prevent movement of the belt to allow for adjustment. [s. 110. (1) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that direct care staff are provided training on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining that are set out in the Act and Regulations. [s.76.(7) 4].

Direct care staff interviews revealed that there has been no training provided to them on how to minimize the restraining of residents. An interview with the Acting Director of Care confirmed that the home has not provided any training on how to minimize the restraining of residents in accordance with the requirements for restraining as set out in the Act and Regulations. [s. 76. (7) 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 to ensure that direct care staff are provided training on how to minimize the restraining of residents and how to restrain in accordance with the requirements for restraining that are set out in the Act and Regulations, to be implemented voluntarily.

WN #3: 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. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that training is provided for all staff who apply physical devices or who monitor residents restrained by a physical device including: the application of these physical devices, use of these physical devices, and potential dangers of these physical devices. [s.221.(1)5]

Direct care staff interviews revealed that the training on the application of seat belt restraints has not been provided. Staff interviews indicate that they will not adjust any seat belt restraint used in the home as they have not been instructed on the application and will only use the seat belt restraint as it is found in the wheelchair. An interview with the Acting Director of Care confirmed that only 15 out of 74 staff members received training on the application of seat belt restraint devices used in the home. [s. 221. (1) 5.]

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 training is provided for all staff who apply physical devices or who monitor residents restrained by a physical device including: the application of these physical devices, use of these physical devices, and potential dangers of these physical devices, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2012_078202_0019	202

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 7th day of March, 2013

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2013_168202_0013
Log No. / Registre no:	T-1798-12, T-95-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 7, 2013
Licensee / Titulaire de permis :	ATK CARE INC. 1386 INDIAN GROVE, MISSISSAUGA, ON, L5H-2S6
LTC Home / Foyer de SLD :	RIVER GLEN HAVEN NURSING HOME 160 High Street, P.O. Box 368, Sutton West, ON, L0E-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KAREN RYAN

To ATK CARE 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2012_078202_0021, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that when a resident is restrained by a seat belt that staff apply the seat belt in accordance with any manufacturer's instructions and the physical device is well maintained. Please submit plan to valerie.johnston@ontario.ca by March 29, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that staff apply all seat belt restraints used in the home in accordance with any manufacturer's instructions and that the seat belt restraints used are well maintained. [s.110.(1)(2)]

A review of the manufacturer's instructions by 'Body Point' for application of seat belt restraints used in the home, titled 'The Hip Belt User's Guide by Body Point' states, 'keep belt tightened at adjustment straps during fitting and daily use to ensure correct placement. The manufacturer's instructions include a picture of a person wearing a seat belt securely fit between thigh and pelvis with directions to ensure the proper fit. The illustration indicates that the position of a hip belt is fitted by using the A.S.I.S (Anterior Superior Iliac Spine) as a key orientation and the belt is used to maintain the hip at 100 degrees, knees 105 degrees and ankles 90 degrees. An interview with the Acting Director of Care (ADOC) revealed that staff are also directed to use the seat belt application instructions

provided by 'Motion Specialties', titled 'Use of Pelvic Belts in Wheelchairs' which states "close belt and tighten until it is snug across the lower pelvis or thighs".

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Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

(202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 26, 2013

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
Performance Improvement and Compliance 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

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

and the Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 7th day of March, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Valerie Johnston

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