Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 24, 25, 31st, 2011	2011_104_2782_24Jan151829	Critical Incident: O-000163

Licensee/Titulaire
Shepherd Village Inc.
3758/3760 Sheppard Avenue East
Toront, ON, M1T 3K9
Fax: 416-609-8329

Long-Term Care Home/Foyer de soins de longue durée
Shepherd Lodge
3760 Sheppard Avenue East
Toronto, ON, M1T 3K9
Fax: 416-293-6229

Name of Inspector(s)/Nom de l'inspecteur(s)
Judy Macaulay, LTCH inspector, #104

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to the unexpected death of an identified resident.

During the course of the inspection, the inspector spoke with the Administrator, the Director of Care, two nursing supervisors, several registered nursing and PSW staff, the Shoppers Home Health representative, several residents and family members.

During the course of the inspection, the inspector reviewed resident health records, observed resident equipment and reviewed the home's policies.

The following Inspection Protocol was used during this inspection:
Minimizing of restraining

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

1 CO: CO # 001
5 WN
1 VPC

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.35 Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,

(a) to restrain the resident

Findings:

1. A prohibited pen-release belt was in use to restrain an identified resident during this inspection.
2. One staff was unable to immediately remove the pen-release belt for this resident when requested by this inspector.

Inspector ID #:	104

Additional Required Actions:

CO # 001 was served on the licensee on January 27, 2011. Refer to the "Order of the Inspector" form.

WN #2: The Licensee has failed to comply with O. Reg. 79/10, s.112
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:
3. Any device with locks that can only be released by a separate device, such as a key or magnet.

Findings:

1. A houdini restraint belt was observed to be in use for an identified resident during this inspection.
2. A houdini belt was ordered for an identified resident after the LTCHA was proclaimed on July 1, 2010.
   - The prohibited device was replaced by a regular lap belt restraint for this resident just prior to this inspection.
3. The licensee did not ensure that prohibited restraint devices, which could only be released by a separate device, were not in use at the home.

Inspector ID #:	104

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 29(1) Every licensee of a long-term care home,
(b) shall ensure that the policy is complied with.

Findings:

The home's *Minimizing of Restraint Policy and Procedures(NUMM - 155) October 2010* identified that:

1. *"A physician's order shall be obtained for restraint".*
   - A physician's order for Houdini belt done up at front for safety was noted for an identified resident.
   - Progress notes identified that the staff phoned the family to advise that the Houdini belt would be replaced.
   - There was no further notation to indicate that the belt was replaced and no physician order was written to reflect this change.
   - The resident was not restrained by a Houdini belt during the incident.
   - The physician's restraint order did not reflect the change from the Houdini lapbelt to a regular lapbelt restraint for this resident.

2. *"No prohibited devices will be used in Shepherd Village. This list includes any device with locks that can only be released by a separate device, such as a key or magnet eg. Houdini seat belt, and any device that cannot be immediately released by staff".*
   - A Houdini restraint was in place for an identified resident from after July 1, 2010 until just prior to this inspection.
   - A Houdini restraint was in place for another identified resident during this inspection.

3. *"Alternatives to restraining have been considered".*
   - No alternatives to restraining were documented for an identified resident.

4. *"All physical restraints will be checked hourly and the resident repositioned every two hours".*
   - Consistency in hourly monitoring and repositioning every two hours of restrained residents was not evident from the staff who were interviewed or from documentation on the restraint records of two identified residents.
   - The Care Guide, Restraint Monitoring Record and the Care Plan did not identify that hourly monitoring was required for an identified resident.

5. *"The resident's condition is reassessed and the effectiveness of the restraining evaluated by registered nursing staff at least every eight hours".*
   - Consistency in documentation of evaluation of restraints by registered staff was not evident on the Medication Administration Record for an identified resident.

6. *"Restraint type and reason must be documented in the record and plan of care".*
   - An identified resident had a lap belt restraint but this device was not documented on the Care Plan.
   - This resident's Care Plan and Care Guide identified 2 half siderails and for staff to check release restraint every 2 hours reposition/reapply.
   - The restraint monitoring record did not include that the type of restraint was a houdini belt closure when it was in use.

7. *"Annual program evaluation will be conducted by Shepherd Village to determine effectiveness of the policy. A written record will be kept and including monthly analysis result."*
   - A written record of a formal annual evaluation of the restraint program was not evident.

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraint policy is complied with including:

- physician's order for restraint,
- alternatives for restraint,
- hourly monitoring of restrained residents,
- repositioning of restrained residents every two hours,
- reassessment of need for restraint every eight hours by registered staff,
- documentation of type of restraint and reason for restraint on the care plan,
- annual evaluation of the restraint program is completed.

This plan to be implemented voluntarily.

Inspector ID #	104

WN #4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, 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,

(c) clear directions to staff and others who provide direct care to the resident.

(4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Findings:

1. Clear directions to staff who provide direct care to restrained residents were not evident.
   - Care Plans for identified residents did not identify that hourly monitoring of restraints was required.
   - The Care Guide, which provides specific resident care information for PSWs to complete care, did not identify that hourly monitoring was required for these restrained residents.
   - The Restraint Monitoring Record, the area where restraint documentation is noted, did not identify that hourly monitoring was required for these restrained residents.
   - Three PSW staff who were interviewed did not identify that restrained residents were required to be monitored on an hourly basis.
     - One staff noted that they would check on the restrained resident whenever they went by their room.
     - Another staff noted that they would check "every so often".
     - Another staff noted that they would check the restrained resident every fifteen minutes.

2. Staff did not collaborate to reflect current mobility status.
   - Interviewed staff confirmed that an identified resident was not ambulatory.
   - This resident's Care Plan and Care Guide noted that the resident was ambulatory.
   - This resident's quarterly assessment noted that they were not ambulatory.

3. Staff did not collaborate to reflect current restraint in use.
   - The care plan and care guide did not identify that either a lapbelt or a houdini belt were in use for an identified resident.
   - The restraint record noted that a lap belt was in use.
   - The physician's order reflected a houdini belt.

Inspector ID #:	104

WN #5: The Licensee has failed to comply 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:

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.

(7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
6. All assessment, reassessment and monitoring , including the resident's response.
7. Every release of the device and all repositioning.

Findings:

1. The requirement that alternatives to restraint be documented was not complied with:
   - The home has a policy for alternatives to restraint as well as an "alternatives to restraint" form.
   - Alternatives to restraint were not documented for an identified resident.

2. The requirement that the person who made the order, and what device was ordered be documented was not complied with:
   A physician's order for Houdini belt done up at front for safety was written.
   - The progress notes identified that the staff phoned this resident's family to advise that the Houdini belt would be replaced by a lap belt.
   - This resident was not restrained by a Houdini belt during the incident.
   - There was no further notation to indicate that the belt was replaced.
   - There was no physician's order documented to reflect this change.

3. The requirement that the monitoring of restrained residents at least every hour be documented was not complied with:
   - Care Plans for identified residents did not identify that hourly monitoring of restraints was required.
   - The Care Guide, which provides specific resident care information for PSWs to complete care, did not identify that hourly monitoring was required for these restrained residents.
   - The Restraint Monitoring Record, the area where restraint documentation is noted, did not identify that hourly monitoring was required for these restrained residents.
   - Three PSW staff who were interviewed did not identify that restrained residents were required to be monitored on an hourly basis.
     - One noted that they would check on the restrained resident whenever they went by their room.
     - Another noted that they would check "every so often".
     - Another noted that they would check the restrained resident every fifteen minutes.

4. The requirement that the release and repositioning every two hours of restrained resident be documented was not complied with.
   - Restraint monitoring records for two identified residents noted periods of greater than two hours with no repositioning documented.
   - Interviewed staff were not consistent in their understanding that restrained residents were required to be repositioned every two hours or that repositioning was to be documented.

5. The requirement that documentation for assessment of effectiveness of restraints every eight hours by a registered staff member was not complied with. o Registered staff signatures were missing on several occasions.

Inspector ID #:	104

CORRECTED NON-COMPLIANCE **Non-respects à Corrigé**				
REQUIREMENT EXIGENCE	**TYPE OF ACTION/ORDER**	**ACTION/ ORDER #**	**INSPECTION REPORT #**	**INSPECTOR ID #**
LTCHA, 2007, S.O. 2007, c.8, s.35	C.O.	#001	2011_104_2782_24Jan151829	104

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** J Macaulay, LTCH inspector - nursing
Title: **Date:**	**Date of Report:** April 14, 2011

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Judy Macaulay	**Inspector ID #**	104
Log #:	O-000163		
Inspection Report #:	2011_104_2782_24Jan151829		
Type of Inspection:	Critical Incident		
Date of Inspection:	Jan 24, 25, 2011		
Licensee:	Shepherd Village Inc. 3758/3760 Sheppard Avenue East Toronto, ON, M1T 3K9 Fax: 416-609-8329		
LTC Home:	Shepherd Lodge 3760 Sheppard Avenue East Toronto, ON, M1T 3K9 Fax 416-293-6229		
Name of Administrator:	Brock Hall		

To Shepherd Village Inc, you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)]
Pursuant to: The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.35(a) Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident, (a) to restrain the resident			
Order: The licensee shall refrain from using any device with locks that can only be released by a separate device and that cannot be immediately released by staff, to restrain any residents and in particular an identified resident.			

Grounds:

1. A prohibited pen-release belt was in use to restrain an identified resident during this inspection.
2. One PSW staff was unable to immediately remove the pen-release belt when requested to by this inspector.

This order must be complied with by:	Immediately

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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.

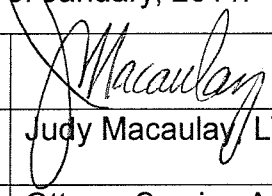
The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with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

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 27th day of January, 2011.	
Signature of Inspector:	
Name of Inspector:	Judy Macaulay, LTCH Inspector-nursing
Service Area Office:	Ottawa Service Area Office