Ontario

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

Rapport d'inspection prévue la *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

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

☐ **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**
September 24 and 27, 2010	2010_126_8564_Sep124108 201_134_8565_24Sep123912	Log # O-001726 Critical Incident

Licensee/Titulaire
Religious Hospitalers of St Joseph of Cornwall, Ontario
14 York Street
Cornwall, On K6J 5T2
Fax: 613-933-0163

Long-Term Care Home/Foyer de soins de longue durée
St Joseph's Continuing Care Centre
14 York Street
Cornwall, On K6J 5T2
Fax: 613-933-0163

Name of Inspector(s)/Nom de l'inspecteur(s)
Colette Asselin # 134 and Linda Harkins # 126

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspectors spoke with staff and management team members, the Pharmacist and the occupational therapist.

During the course of the inspection, the inspectors visited the resident's room, reviewed the resident's Health Records, some policies and work routines.

The following Inspection Protocols were used during this inspection:

1. Minimizing Restraint
2. Falls Prevention
3. Responsive Behavior

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

6 WN
2 VPC
3 CO: CO # 001, # 002, # 003

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.)	

WN #1: 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.

(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.

(10)The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective.

Findings:

1. The resident's care plan did not provide clear direction to staff as to what interventions to implement when the resident was awake and agitated at night.
2. The resident's care set out in the plan of care was not provided as specified in the plan.
3. The plan of care was not revised to indicate changes in the resident's care needs.
4. The plan of care was not reviewed and revised to address the resident's individualized care needs.

Inspector ID #:	# 134 and # 126

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 meeting the requirement that the residents' plans of care provide clear direction to staff and are updated when the residents' care needs change, to be implemented voluntarily.

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

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.

Findings:

1. The resident was known to slide in his wheelchair. There are several entries in the progress notes to indicate that the resident had a tendency to slide while in wheelchair.
2. There is an entry indicating the power of Attorney, was called and informed of the restraint procedure and consequences of receiving or refusing restraint. There is no entry related to the response to the application of the seatbelt noted on the pre-restraint assessment form or in the progress notes.
3. The physician's order for seatbelt was not processed correctly and there is an error in transcription of this order on the Quarterly Physician's Order Review sheet that led staff to think that the order had been discontinued.

Inspector ID #:	134 and 126

WN # 3 : The Licensee has failed to comply with O. Reg. 79/10, s. 110 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

4. Consent.

5. The person who applied the device and the time of application.

6. All assessment, reassessment and monitoring, including the resident's response.

7. Every release of the device and all repositioning.

8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Findings:

1. On the pre-restraint assessment form, there is an entry indicating the power of Attorney was called and informed of the restraint procedure and consequences of receiving or refusing restraint. There is no entry related to the response to the application of the seatbelt noted on the pre-restraint assessment form or in the progress notes.
2. The restraint documentation flow sheet had been discontinued and no other source of documentation was found for staff monitoring and documentation. The time of application and the person who applied the device, the times for removal, the time of repositioning and of the release of the device, were not documented.
3. The use of the front pen release seatbelt applied to a resident, was not documented as it relates to; person who applied the seatbelt and the time of application, the resident's response to being restrained, the release of the device and all repositioning.

Compliance order # 003 was faxed to the licensee on October 12, 2010

Inspector ID #:	134 and 126

WN # 4 : The Licensee has failed to comply with 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:

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.

Findings:

1. A resident who slid down on the floor had a front pen release seat belt under his neck. This resident was unresponsive with no pulse and no respiration and was later pronounced dead on site by the Coroner.

2. The Registered Practical Nurse (RPN), the Nurse in Charge, stated she was not informed that a front pen release seat belt was applied on the resident during the night shift.

3. Two Resident Care Assistants (RCA) stated they did not monitor a resident at least every hour and had not released the physical device and had not repositioned the resident at least once every two hours, between the time of the application of the front pen release seat belt and the time the resident was found unresponsive.

Compliance order # 002 was faxed to the licensee on October 4, 2010

Inspector ID #:	134 and 126

WN # 5 : 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:

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:

1. A resident was found in the bedroom in front of the wheelchair with the front pen release seatbelt under his neck
2. The front pen release seat belt is a device with lock that can only be released by a separate device such as a key. This type of restrain was prohibited as of July 1, 2010

Compliance order # 001 was faxed to the licensee on October 4, 2010

Inspector ID #:	134 and 126

WN # 6: The Licensee has failed to comply with In the LTCHA, 2007 S.O. 2007, s.29 (1) there is a requirement that states that the licensee shall ensure there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and that the policy is complied with.

Findings:

1. The home's has a "Least Restraint Policy" # 11- a -178, which was last reviewed in October 2007.
2. Sections 4.4, 4.5, 4.6 and 4.7 of this policy were not complied with, which relates to monitoring of restraints, documentation on flow sheet, revision of orders/quarterly, resident's response to restraint.

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 meeting the requirement that, the home complies with their policies and work routines or to revise them as needed, to be implemented voluntarily.

Inspector ID #:	134 and 126

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.
Title: Date:	Date of Report: October 12, 2010

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:	Colette Asselin	**Inspector ID #**	134
Log #:	O-001726		
Inspection Report #:	2010_134_8565_24Sep123912		
Type of Inspection:	Critical Incident		
Date of Inspection:	September 24 and 27, 2010		
Licensee:	Religious Hospitalers of St-Joseph of Cornwall, Ontario 14 York Street Cornwall, ON K6J Fax: 613- 933-0163		
LTC Home:	St-Joseph's Continuing Care Centre 14 York St Cornwall, ON K6J 5T2 Fax: 613-933-0163		
Name of Administrator:	Bonnie Ruest		

To Religious Hospitalers of St-Joseph of Cornwall, Ontario, you are hereby required to comply with the following orders by the dates set out below:

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: O. Reg. 79/10, s. 110 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

4. Consent.

5. The person who applied the device and the time of application.

6. All assessment, reassessment and monitoring, including the resident's response.

7. Every release of the device and all repositioning.

8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Order: The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirements related to the documentation of every use of a physical device as it relates to: consent; person who applied the device and the time of application; assessment and monitoring including the resident's response; every release of the device and all repositioning and the time of removal of the device.
Grounds: 1. On the pre-restraint assessment form, there is an entry indicating the power of Attorney was called and informed of the restraint procedure and consequences of receiving or refusing restraint. There is no entry related to the response to the application of the seatbelt noted on the pre-restraint assessment form or in the progress notes. 2. The restraint documentation flow sheet had been discontinued and no other source of documentation was found for staff monitoring and documentation. The time of application and the person who applied the device, the times for removal, the time of repositioning and of the release of the device, were not documented. 3. The use of the front pen release seatbelt applied to a resident, was not documented as it relates to; person who applied the seatbelt and the time of application, the resident's response to being restrained, the release of the device and all repositioning.

This order must be complied with:	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 12 day of October, 2010.	
Signature of Inspector:	Colette Asselin
Name of Inspector:	Colette Asselin
Service Area Office:	Ottawa

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:	Linda Harkins	**Inspector ID #**	126
Log #:	O-001726		
Inspection Report #:	2010_126_8565_24Sep124108		
Type of Inspection:	Critical Incident		
Date of Inspection:	September 24 & 27, 2010		
Licensee:	Religious Hospitalers of St. Joseph of Cornwall, Ontario 14 York St Cornwall, ON K6J 5T2 Fax: 613-933-0163		
LTC Home:	St Joseph's Continuing Care Centre 14 York St Cornwall, ON K6J 5T2 Fax: 613-933-0163		
Name of Administrator:	Bonnie Ruest		

To Religious Hospitalers of St. Joseph of Cornwall, Ontario, you are hereby required to comply with the following orders by the dates set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: 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:

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.

Order: The Licensee shall not use any prohibited devices that limit movement within the Long Term Care Home as identified in O. Reg. 79/10, s.112, including front pen release seat belt.

Grounds:

1. A resident was found in his bedroom in front of his wheelchair.
2. The front pen release seat belt, a device with lock that can only be released by a separate device is prohibited.

Compliance order # 001 was faxed to the licensee on October 4, 2010

This order must be complied with:	immediately

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: The Licensee has failed to comply with 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:

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.

Order: The Licensee shall monitor residents that are being restrained by a physical device at least every hour by a member of a registered staff or by another member of staff and release those residents from the physical device and reposition them at least once every two hours.

Grounds:

1. A resident who slid down on the floor had a front pen release seat belt under his neck. This resident was unresponsive with no pulse and no respiration and was later pronounced dead on site by the Coroner.

2. The Registered Practical Nurse (RPN), the Nurse in Charge, stated she was not informed that a front pen release seat belt was applied on the resident during the night shift.

3. Two Resident Care Assistants (RCA) stated they did not monitor a resident at least every hour and had not released the physical device and had not repositioned the resident at least once every two hours, between the time of the application of the front pen release seat belt and the time the resident was found unresponsive.

Compliance order # 002 was faxed to the licensee on October 4, 2010

This order must be complied with:	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.

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(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:.

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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 4th day of October, 2010.	
Signature of Inspector:	L Harkins
Name of Inspector:	Linda Harkins
Service Area Office:	ottawa