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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 28, 2018	2018_694166_0026	029224-18	Resident Quality Inspection

Licensee/Titulaire de permis

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194), JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 13, 14, 15,19, 20, 21, 22, 23, 26, 27, 28, 29, 30, December 3,4,5,6,7 2018

Critical Incidents:
(log #002155-18) related to an allegation of resident to resident abuse
(log #003823-18) related to an allegation of resident to resident abuse
(log #005628-18) related to an allegation of resident to resident abuse
(log #006343-18) related to an allegation of resident to resident abuse

(log #009747-18) related to an allegation of resident to resident abuse
(log #009783-18) related to an allegation of resident to resident abuse
(log #009747-18) related to an allegation of resident to resident abuse
(log #006343-18) related to an allegation of resident to resident abuse
(log #005610-18) related to an allegation of resident to resident abuse
(log #023272-18) related to an allegation of resident to resident abuse
(log #022995-18) related to an allegation of resident to resident abuse
Critical Incidents:
(log #002155-18) related to an allegation of staff to resident abuse
(log #005610-18) related to an allegation of staff to resident abuse
Critical Incidents:
(log #000761-18) related to a resident fall,
(log #014414-18) related to a resident fall
Complaint log #013599-18 related to insufficient staffing
Complaint log #019264-18 related to the communication system in the home
Complaint log #005143-18 related to diet changes, were all inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Substitute Decision Makers(SDM), Administrator, Director of Care(DOC), Personal Support Workers(PSW), Registered Practical Nurses(RPN), Registered Nurses(RN), representative of the Resident's Council, representative of the Family Council, Food Service Worker, Registered Dietitian, Environmental Manager(ESM), Director of Quality and Education (DQE), Manager of Strategies and Special Projects, Nurse Managers, Behaviorial Support Ontario staff member(BSO), Manager of Programming, Schedule Analyst and Manager of Finance.

During the course of this inspection, the inspectors toured the residents' home and common areas, observed the residents and staff during the provision of care and during recreational activities.The inspectors observed dining and nourishment services, infection control practices and medication administration.

During the course of this inspection, the inspectors reviewed clinical health records, the licensee's documentation related to mandatory investigations, staffing plans and schedules and the licensee's policies related to falls prevention, pain and abuse.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **7 VPC(s)**
- **0 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	Légende 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1.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.

Related to resident #031

Resident #031 triggered through to Stage II of the Resident Quality Inspection(RQI) specific to Minimizing of Restraining, related to an observation conducted by inspector #166, indicated the resident had a safety support attached to the mobility device, which the resident could not release independently.

Review of the physician's orders indicated due to high risk of falls, a safety support was to be applied when the resident was up in the mobility device.

Review of resident #031's clinical records and current written plan of care, indicated the resident was a very high risk for falls, was part of the falling star program with a logo to be posted in the resident's bedroom door frame, the resident also required a safety support to be attached to the back of the mobility device at all times while up and transferred to the bed when resting.

On a specified date, inspector #672, observed resident #031 self- propelling the mobility device There were no safety supports in place and no logo was posted outside on the resident's door frame.

On a specified date, interview with RPN #100 indicated being aware that resident #031

had a physician's order for the use of a safety support while in the mobility device. RPN #100 further indicated that resident #031 had received a new mobility device which should have had a safety support attached.

Review of resident #031's progress notes indicated resident #031, after receiving the new mobility device, had three falls during a 24 hour period of time, which had resulted in the resident sustaining injuries.

Following the fall, staff transferred the resident back into resident #031's previous mobility device with the safety support attached.

On a specified date, interview with PSW #106 indicated, the PSW had been present, when resident #031's new mobility device had been delivered but had not noticed that the safety support was not attached. PSW #106 further indicated being aware that resident #031 was at high risk for falls but was unaware that all the safety supports were required while the resident was up in the mobility device.

An interview with RPN #127 indicated that resident #031 was part of the falling star program and that a logo should have been be posted on the resident's bedroom door frame.

The licensee failed to ensure that the care set out in resident #031's plan of care was provided to the resident as specified in the plan, by not ensuring all the safety supports were attached when the resident had received and was up in the new mobility device; and not ensuring that a logo was posted in the bedroom door frame. [s. 6. (7)]

2. The licensee has failed to ensure that when a resident was reassessed and the plan of care revised, different approaches were not considered in the revision of the plan of care.

Related to resident #054

The plan of care for resident #054 related to falls indicated several intervention were in place.

Review of the clinical health record for resident #054 indicated the resident had incurred three falls since admission to the home.
- PSW staff entered resident #054's room to find the resident sitting on the floor at the

foot of the bed. Resident #054 was not injured.
- Charge Nurse reported resident #054 was found sitting on the dining room floor. Resident #054 was not injured, but the resident's had removed their shoes.
- PSW reported resident #054 was found lying on the floor in front of the resident's bathroom. Resident #054 was assessed and documentation indicated no injury. (resident #054 was later transferred to hospital for further assessment related to increased pain).

Review of the clinical health record for resident #054 indicated that a Morse Falls assessment and review of the Alternative to Restraints assessment (to be completed post falls) as well as Head Injury Routine was completed for resident #054.

There were no different approaches related to falls management considered in the revision of the plan of care for resident #054.

During completion of the Falls inspection, inspector #194 expanded the resident sample to include resident #031.

Related to resident #031

Resident #031 is described in the care plan as being dependent on staff for all activities of daily living (ADL); and used a mobility device dependent with ability to self propel.

Review of the clinical health record for resident #031 related to falls, during a specified period of time, it was noted that the resident had a number of falls.

Review of the clinical health record indicated that Head Injury Routine, Alternative to Restraints, Abbey Pain Scale and Morse Falls Assessment had been completed for resident #031 for each identified fall.

The plan of care for resident #031 related to falls indicated a number of interventions were in place.

During an interview with inspector #194, related to resident #031's falls, RPN #125 was able to explain the process related to documentation for falls in the home. RPN #125 reviewed resident #031's Alternative to Restraint form with inspector #194.

During an interview with inspector #194, RN #117 (who is on the falls prevention team)

indicated that resident #031 had been discussed during a falls prevention team meeting and that all required interventions were already in place for the resident.

The licensee failed to ensure that when resident #031 was being reassessed related to falls, that different approaches were considered in the revision of the plan of care. [s. 6. (11) (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 the care set out in residents' plan of care is provided to residents as specified in their plans and that when a resident is reassessed and the plan of care reviewed, revised and if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 the licensee's Falls Prevention and Management Program was complied with.

Under O.Reg, 79/10 s. 48 (1) Every licensee of a long term care home shall ensure that

the following interdisciplinary programs are developed and implemented in the home:
A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Under O.Reg 30 (1) Every licensee of a long term-care home shall ensure that the following is complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The Licensee's Falls Prevention and Management Program ; Policy #8-41 dated March 2017 directs:

RESPONSIBILITY OF THE RN/RPN
Initiate Head injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy
Perform HIR as per policy
-every 15 minutes for the first hour post injury
-every 30 minutes for the next two hours
-every 4 hours for the remainder of the 24 hour period post fall assessing for signs of neurological changes (eg. facial droop, behaviour changes and one-sided weakness) complete an incident report in Point Click Care (PCC) including the Morse Fall Risk and Abbey Pain assessment.
Document in the progress notes:
Who was notified of the falls (eg Physican, POA) probable cause of the fall, resident outcomes and interventions taken to prevent further falls or related injury.

Related to Log # 000761-18

Review of a Critical Incident Report and clinical health records for resident #054 for a fall on a specified date, indicated that resident was found lying on the floor in front of the resident's washroom. Resident #054 was unable to describe what occurred and was assessed with no injuries found.

Later, during that same specified date, resident #054 was assessed by the oncoming registered staff and the resident was observed to be in increased pain, with bruising and

was transferred to the hospital for further assessment and treatment.

Review of resident #054's clinical records indicated the resident was ambulating independently prior to the fall. Further review indicated that there was no Morse Falls Risk assessment completed on the date of the fall, no Head Injury Routine and the progress notes did not indicate probable cause of the fall or resident outcomes and interventions taken to prevent further falls or related injury.

The licensee's failed to comply with their Falls Prevention Management policy for resident #054 post fall, when the the Morse Fall Risk and progress notes were not completed as per the licensee's policy. [s. 8. (1) (a),s. 8. (1) (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 the licensee shall ensure 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, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's flooring was in a safe condition and in a good state of repair.

During the Resident Quality Inspection(RQI) a tour of the building was completed. During the tour it was noted that the flooring in three of the resident tub rooms were in disrepair.

-an identified tub room – ½ inch separation on the flooring in the center of the room by the tub approximately 2 feet in length, unable to clean and sanitize properly creating a potential for infection.

-an identified tub room –3 foot separation on the floor on the outside wall of the room is taped. Large gap, unable to clean and disinfect area, would possible allow water into area.

-an identified tub room - cracks in flooring around the tub was noted, and a major crack is noted on the far side of the floor by the wall – taped – approximately 4 feet in length, tape also noted on the floor by the ½ wall near the toilet.

Interview with the Environmental Service Manager(ESM) related to flooring indicated to inspector #194 that the home was aware of the concerns related to flooring in the tub rooms and plans to address the concern were discussed. Inspector #194 was provided a copy of the homes Capital Plan summary dated November 2018 indicated that an allocation for flooring in the identified rooms have been set in the 2019 budget

These areas of disrepair create a potential risk to the health, comfort, safety and well being of residents and may negatively impact the ability of staff to clean effectively. [s. 15. (2) (c)]

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 the licensee shall ensure that the home in case specifically the flooring in the tub rooms are kept maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. Abuse of a resident by anyone that resulted in harm or risk of harm.

Log #004842-18,

A Critical Incident Report(CIR) was submitted to the Director reporting an alleged incident of resident to resident sexual abuse.

Review of the CIR indicated, resident #062 was observed attempting to touch resident #063 inappropriately. The residents were separated and the incident was reported the Registered Practical Nurse, who in turn reported the incident to the Charge Nurse. The incident was reported to the Director, three days after the occurrence of the incident.

Log # 022995-18

A CIR was submitted to the Director reporting an alleged incident of resident to resident physical abuse. .

Review of the CIR indicated that on a specified date, RPN #122 heard yelling in the hallway. RPN #122 documented in the progress notes that resident #067 and resident #066 had a physical altercation. RPN #122 informed RN #132 of the incident. RN #132 initiated the investigation, completed the home's incident report and documented that the Dietitian (who was manager in charge, the date of this incident) was notified of the incident. The incident was reported to the Director, the day after the incident occurred.

Log 005628-18

A Critical Incident Report(CIR) was submitted to the Director reporting an alleged incident of resident to resident abuse.

Review of the CIR documentation indicated, PSW#130, saw resident #053 get up and turn off the lights in the TV room. The PSW reported hearing the sound of three kisses. RPN #136 asked if resident #072 was ready to go back to the resident's room and while taking the resident back, the RPN asked the resident if they and resident #053 were kissing. Resident #072 confirmed they were kissing and it was consensual.
In a discussion with RPN #136, resident #053, made the allegations that resident #072 had made an inappropriate request and gesture towards resident #053.

The police and both residents' Substitute Decision Makers(SDM) were immediately notified of the allegations of resident to resident abuse.

The allegations of resident to resident abuse was reported to the Director, two days after the incident occurred.

Log #005610-18

Inspector #194 reviewed the information provided in a Critical Incident Report(CIR) related to allegations of staff to resident abuse. The CIR described that PSW #137 alleged that PSW #138 told resident #078 to go back to bed and then placed a chair in front of the resident's room to prevent the resident from getting out.

The CIR and licensee's internal investigation indicated that PSW #137 suspected abuse by PSW #138, but did not immediately report the allegation. PSW #137 reported the alleged abuse to RN #139, the day after the incident had allegedly occurred.

During a telephone interview with inspector #194, RN #139 indicated that they did not notify the Director as there were no injuries to the resident. The incident was reported to the Director, the day following the incident.

During interview with inspector #194, the Manager of Education and Quality clarified that the home's practice for report any abuse was that Registered Nurse (Charge Nurse) on duty after hours and on weekends/holidays would be responsible for notifying the Director any incidents involving resident abuse.

The licensee failed to ensure, related to the above alleged incidents, that persons who had reasonable grounds to suspect that abuse of a resident had occurred immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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 any person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident had their personal items labelled within 48 hours of admission and in the case of acquiring new items.

During Stage I of the RQI, Inspector #672 made observations of a number of unlabeled personal items within different resident home areas and tub/shower rooms throughout the home

During an interview with PSW #122, indicated they were unable to identify to whom the items in the tub/shower room belonged and believed they were "extras to be used" for any resident during or following their bath or shower, if they forgot to bring or didn't have their own personal care items.

During separate interviews with PSW# 121 and PSW #124 indicated they did not know to whom, the unlabeled items in a specified tub room belonged to. PSW #124 further indicated that the bottles of perfumes and colognes were used for any resident, following completion of the bath or shower. PSW #121 further indicated that the personal care items stored in the bath/shower room were routinely utilized by staff if the resident forgot or didn't have their own personal care items.

During an interview with the Director of Quality and Education indicated that the expectation in the home was that every resident had their own personal care items, which were to be labelled with their name.

The licensee failed to ensure that each resident had their personal items labelled within 48 hours of admission and in the case of new items, of acquiring. [s. 37. (1) (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 to ensure ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Log #000761-18

Resident #054 was diagnosed with a significant injury related to a fall and was transferred to the hospital for further treatment. Upon return to the home, resident #054 was prescribed a pain medication for discomfort to be administered 4 times a day as well as a narcotic pain medication every 4 hours when needed (PRN).

Review of the Medication Administration Record (MARS) indicated resident #054 received the narcotic pain medication six times in a 24 hour period. The MARS indicated that the PRN narcotic pain medication was not effective on three of the six times administered.

Review of the assessments related to pain for resident #054 in Point Click Care indicated that a Abbey Pain assessment was completed only once and indicated mild pain, no further assessments were found.

The licensee has failed to ensure that when resident #054's pain was not relieved by initial interventions, is the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

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 ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: 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:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

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. O. Reg. 79/10, s. 110 (7).

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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff applied physical devices that were ordered or approved by a physician or registered nurse in the extended class.

Related to resident #069

Resident #031 triggered through to Stage II of the RQI specific to Minimizing of Restraining. Non-compliance was observed related to resident #031, therefore the scope was expanded to include resident #069, who had a safety support in place and when asked by inspector #672, the resident was unable to unclip the safety support.

Review of resident #069's health care records and during separate interviews with PSWs #131, #128 and RPN #119, indicated that resident #069 had been using the safety support while in the mobility device for approximately two months due to the resident being at high risk for falls. The resident recently had multiple falls, one of which resulted in the resident sustaining a significant injury. Since the fall, staff had been consistently applying the safety support when the resident was up in the mobility device, as the resident had been continuously trying to stand during the day and was at risk for further falls.

Inspector #672 reviewed resident #069's physician's orders and did not find an order for the use of a safety support. Inspector #672 then reviewed resident #069's physician's orders with RPN #128 and RPN #119 and no order related to the use of a safety support for resident #069 could be found.

The licensee failed to ensure that staff only apply a physical safety support that was ordered or approved by a physician or registered nurse in the extended class. Resident #069 had a safety support applied daily without an order present. [s. 110. (2) 1.]

2. Related to resident #069

Resident #031 triggered through to Stage II of the RQI specific to Minimizing of Restraining. Non-compliance was identified related to resident #031, therefore the scope was expanded to include resident #069, who had a safety support in place and when asked by inspector #672, the resident was unable to unclip the safety support.

During separate interviews PSWs #131, #128 and RPN #119 indicated that resident #069 had been using the safety support while in the mobility device for approximately two months due to the resident being at a high risk for falls. Resident #069 had a number falls in a specified period.

Inspector #672 reviewed resident #069's clinical records and did not observe a consent

for the use of a safety support from resident #069's Substitute Decision Maker (SDM). Inspector #672 reviewed resident #069's clinical records with RPN #128 and RPN #119, and no consent related to the use of a safety support could be observed.

During separate interviews RPN #128, RPN #119 and RN #117 indicated that consent from the SDM was required prior to a safety support being applied to a resident. RN #117 further indicated they would follow up and assess the resident for the need for the safety support and obtain an informed consent from the SDM, if the safety support was required.

The licensee failed to ensure that an informed consent by resident #069's SDM had been received and documented, prior to the use of a safety support for resident #069. [s. 110. (7) 4.]

3. The licensee has failed to ensure that the documentation included every release of the safety support, and repositioning of the resident while being restrained.

Related to resident #031 and resident #069

During an interview with Inspector #672, RPN #100 indicated that the expectation in the home was that PSW staff were to document on every residents' use of a safety support within the POC documentation system to indicate when the safety support had been applied and removed, along with resident repositioning every two hours. The Registered staff were to document on every resident safety device once per shift, in the Electronic Medication Administration Record (eMAR), to indicate that the resident had been assessed, and the safety support was still required and applied appropriately.

During an interview PSW #106 indicated the expectation in the home was that each resident with a safety support should be documented on within the POC system every two hours.

Related to resident #031

Inspector #672 reviewed resident #031's eMAR for a 3 month period of time and observed that the documentation required for the safety support was being completed by the registered staff three times per day, once per shift.
Inspector #672 then reviewed the POC documentation for the PSW staff, but could not observe any documentation to indicate that resident #031's safety support was being

applied or released, or that the resident was being repositioned every two hours.

During an interview with inspector #672, PSW #106 could not recall documenting on the safety support use for resident #031 within the POC documentation system.

Related to resident #069.

During an interview with PSW #131, who indicated being the primary PSW for resident #069, could not recall documenting on the safety device use for resident #069 within the POC documentation system.

Inspector #672 reviewed the POC documentation and did not observe any documentation from the PSW staff related to resident #069's safety support, to indicate that the safety support was being applied or removed, or that the resident was being repositioned every two hours.

Inspector #672 then reviewed resident #069's eMAR and did not observe any documentation from the registered staff related to the safety support to indicate that the resident had been assessed, the safety support was still required and had been applied appropriately.

During an interview the Director of Quality and Education (DQE) indicated that the expectation in the home was that when an order was obtained for a resident to begin to utilize a safety support, the order was to be added to the eMAR system for the registered staff to document on the safety support once per shift, and to the POC system for the PSW staff to document on every two hours, to indicate that the safety support was being applied, the resident was being repositioned every two hours, and how the resident tolerated the use of the safety device.

The licensee failed to ensure that the documentation for resident #031 and resident #069 included every release of the safety support, repositioning of the resident and whether the safety support was still required and had been applied appropriately. [s. 110. (7) 7.]

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 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, and a consent for the use of the restraint/seat belt is documented and that every release of the device and all repositioning is also documented, to be implemented voluntarily.

WN #8: 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 has failed to ensure that the "Abuse and Neglect (Resident) - Zero Tolerance" policy # 14-18 dated March 2018 was complied with.

During the inspection of a Critical Incident Report related to allegations of staff to resident emotional abuse, inspector #194 reviewed the home's abuse policy, CIR documentation and internal abuse investigation.

Review of the licensee's "Abuse and Neglect (resident) - Zero Tolerance" Policy # 14-18 dated March 2018 indicated;

All those who witness or have knowledge or reasonable grounds for suspicion of the abuse are required to report it to the Charge Nurse immediately in accordance with section 24(1) of the LTCHA.

Review of the CIR indicated that PSW #137 witnessed PSW# 138 tell resident #078 to go to bed and then place a chair in front of the resident's door so the resident could not exit the room. PSW #137 indicated in CIR and internal investigation that they did not report the allegations immediately to the charge nurse as they did not really know if it was reportable.

PSW #137 was not interviewed as is no longer an employee of the home. PSW #138 was not available for interview at the time of the inspection.

Review of the internal investigation into the allegations of emotional abuse towards resident #078 was completed by inspector #194. The internal investigation indicated that PSW #137 reported the allegations of abuse towards resident #078 the following day to RN #139. The internal investigation by the licensee determined the allegations to be unfounded and PSW #137 was provided with additional mentoring and counseling related to reporting of abuse.

The licensee failed to comply with it's abuse policy when PSW# 137 did not immediately report the allegations of emotional abuse by PSW #138 towards resident #078 . [s. 20. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a safety support was included in the plan of care.

Resident #031 triggered through to Stage II of the RQI specific to Minimizing of Restraining. Non-compliance was observed related to resident #031, therefore the scope was expanded to include resident #069, who had a safety support in place.

Review of resident #069's health care records and during separate interviews with PSWs #131, #128 and RPN #119, indicated that resident #069 had been using a safety support for approximately two months, due to the resident being at high risk for falls. The resident recently had multiple falls, one of which resulted in the resident sustaining an injury. Since the fall, staff had been consistently applying the safety support when the resident was in the mobility device, as the resident had been continuously trying to stand during the day and was at risk for further falls.

Resident #069 was observed by inspector #672, in a mobility device, with a safety support secured in the front.
Inspector #672 reviewed resident #069's health care records, written plan of care and Kardex, and did not observe any focuses specific to the use of the safety support.
Inspector #672 then reviewed resident #069's physical chart with RPN #127 and RPN #119, and no focus related to a safety support for the resident could be observed.

During separate interviews, RPNs #127 and #119 indicated that the expectation in the home was that all use of a safety supports by residents were to be added to the residents' written plan of care and Kardex, to inform staff of the required equipment, and when the safety supports were to be applied.

The licensee failed to ensure that the safety support was included in the plan of care for resident #069. [s. 31. (1)]

Issued on this 16th day of January, 2019

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

Original report signed by the inspector.