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:	LAUREN TENHUNEN	**Inspector ID #**	196
Log #:			
Inspection Report #:	2012_104196_0013		
Type of Inspection:	Critical Incident		
Date of Inspection:	May 31, 2012		
Licensee:	The McCausland Hospital 208 Cartier Road, TERRACE BAY, ON, P0T-2W0		
LTC Home:	WILKES TERRACE 208 Cartier Road, TERRACE BAY, ON, P0T-2W0		
Name of Administrator:	Paul Paradis		

To The McCausland Hospital, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	002	**Order Type:**	[e.g. Compliance Order, Section 153 (1)(a)]

Pursuant to: 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.

Order: (a) immediately refrain from using, on any resident, any device with locks that can only be released by a separate device, such as a key or magnet and
(b) prepare, submit and implement a plan for achieving compliance with O.Reg.79/10,s.112., that will ensure that prohibited devices that limit movement are not used on residents in the home.
This plan must be submitted in writing to Inspector Lauren Tenhunen at 189 Red River Road, Suite 403, Thunder Bay, ON P7B 1A2 or by fax at 1-807-343-7567 on or before July 17, 2012. Full compliance with this order shall also be July 17, 2012.

Grounds:

1. Resident #002 was observed on May 31, 2012 at 1232hrs, sitting in a wheelchair in the dining room with a "pinel" brand strap around the waist and affixed at the back of the wheelchair with a magnet lock that requires a separate magnet key for release. The home's policy titled "Use of restraints/minimizing restraints" # A1.5 was reviewed by the inspector and it identifies that "pinel" restraints are not approved for use in the home. The licensee failed to ensure their home's policy and the legislation regarding prohibited devices that limit movement, was complied with.
The licensee failed to ensure that devices with locks that can only be released by a separate device, such as a key or magnet, are not used in the home. [O.Reg.79/10,s.112(3).] (196)

This order must be complied with by:	Jul 17, 2012

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 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 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 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.

Amended on January 4, 2013 by by Lauren Tenhunen (196)	
Signature of Inspector:	Lauren Tenhunen #196
Name of Inspector:	Lauren Tenhunen
Service Area Office:	Sudbury

Ontario

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

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
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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

Sudbury Service Area Office
159 Cedar Street, Suite 603
Sudbury ON P3E 6A5

Telephone: 705-564-3130
Facsimile: 705-564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
Sudbury ON P3E 6A5

Téléphone: 705-564-3130
Télécopieur: 705-564-3133

☐ 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
May 31, 2012	2012_104196_0013	Critical Incident

Licensee/Titulaire
The McCausland Hospital
208 Cartier Road, , TERRACE BAY, ON, P0T-2W0

Long-Term Care Home/Foyer de soins de longue durée
WILKES TERRACE
208 Cartier Road, , TERRACE BAY, ON, P0T-2W0

Name of Inspector(s)/Nom de l'inspecteur(s)
Lauren Tenhunen (196)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Inspection.

During the course of the inspection, the inspector(s) spoke with: the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents

During the course of the inspection, the inspector(s): conducted a tour of the home, observed the provision of care and services to residents, reviewed the Critical Incident report submitted to the Ministry of Health and Long -Term Care (MOHLTC), reviewed various home policies and procedures, reviewed the staffing schedule of the home and the health care records of various residents

The following Inspection Protocols were used during this inspection:
Findings of Non-Compliance were found during this inspection.
Minimizing of Restraining
Sufficient Staffing
Critical Incident Response

This report was issued originally on July 4, 2012 by Inspector # 196.

On December 17, 2012, O Reg 79/10. 417/12 was filed which amended O Reg. 79/10, s. 45.1, 2 (2) under the Long-Term Care Homes Act 2007. As a result of this amendment, the original inspection report issued by Inspector # 196 on July 4, 2012 is amended and the order CO 001 and WN # 1 have been rescinded.

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

Findings:

1. Resident #002 was observed on May 31, 2012 at 1232hrs, sitting in a wheelchair in the dining room with a "pinel" brand strap around the waist and affixed at the back of the wheelchair with a magnet lock that requires a separate magnet key for release. The home's policy titled "Use of restraints/minimizing restraints" # A1.5 was reviewed by the inspector and it identifies that "pinel" restraints are not approved for use in the home. The licensee failed to ensure their home's policy and the legislation regarding prohibited devices that limit movement, was complied with.
The licensee failed to ensure that devices with locks that can only be released by a separate device, such as a key or magnet are not used in the home. [O.Reg.79/10,s.112 (3).]

Additional Required Actions:
CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Inspector ID #:	196

WN # 3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings:
1. Resident #001 had a fall with fracture in February 2012. An interview was conducted with staff member #S102 on May 31, 2012 to determine if a post-fall assessment was done on the resident after the fall with injury. It was identified by this staff member that the home's clinical assessment instrument, titled "Morse Fall Scale" was not completed after the resident's fall and staff have been recently informed this is to be completed after a resident fall.
The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [O. Reg. 79/10, s. 49 (2).]

Inspector ID #: 196

WN # 4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

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.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
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.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings:
1. The Inspector observed the use of a prohibited restraining device on a resident in the home on May 31, 2012. Interview was conducted with staff member #S101 and they stated they could not recall any training in the area of restraint use since starting at the home in May 2011 and had thought the home was "zero restraints" and "okay to use a restraint if the family wanted it". An interview was conducted with staff member #S102 and it was identified training for staff members was provided last year upon the opening of the home and they haven't yet started the annual training for staff members. Staff member #S100 and #S101 that had been interviewed by the inspector on May 31, 2012 did not have an understanding of how to minimize restraining of residents and if restraining is necessary, how to do so in accordance with the Act and associated regulations.

The licensee failed to 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: 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. [LTCHA 2007,S.O.2007,c.8,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 that ensures all staff who provide direct care to residents receive training in the area of minimizing the restraining of residents and where restraining is necessary, how to do so in accordance with this Act and the regulations, to be implemented voluntarily.

Inspector ID #: 196

WN # 5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents
Specifically failed to comply with the following subsections:
s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person

designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings:

1. A Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in February 2012 for a resident fall with injury and subsequent transfer to the acute care hospital. The report was reviewed and indicated the staff did not notify the substitute decision maker(SDM) of the transfer to hospital and serious injury until the following day. The report also indicated that the staff members were unaware of the requirements to inform the substitute decision maker (SDM) of a serious injury.
The licensee failed to ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. [O. Reg. 79/10, s. 107 (5).]

Inspector ID #:	196

WN # 6: 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 subsections:
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,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings:

1. Inspector was unable to locate the care plan for resident #001 in the care plan binder. Interview was conducted with staff member #S100 and it was determined there was "no written care plan" for this resident and one had not yet been completed, despite the resident being admitted to the home in May 2011. An interview was conducted with staff member #S101 and it was identified some of the care plans are not completed and that staff don't always look at them, and instead would get information about a resident from the kardex. Inspector reviewed the kardex for resident #001 and noted it did not outline the planned care for the resident, it did not have goals listed and it did not include clear directions to staff and others who provide direct care to the resident.
The licensee failed to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O.2007,c. 8, s. 6 (1).]

Inspector ID #:	196

Amended on this 4th day of January 4, 2013

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

Lauren Lenhunen #196