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 le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 25, 2016;	2016_246196_0002 (A1)	001797-16	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

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

LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The dates for compliance were changed to March 31, 2016.

Issued on this 25 day of February 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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

LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 21, 22, 23, 24, 25, 2016

During the course of the inspection, the inspector(s) spoke with the President and CEO, Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI Coordinators, Medical Director, Clinical Manager, Clinical Resource Coordinator (CRC), residents and family members.

During the course of inspection, the Inspector conducted a daily walk through of resident care areas, observed staff to resident interactions and the delivery of care and services to residents, reviewed the home's staffing plan and RN schedules, reviewed training records of direct care staff, reviewed several resident's health care records.

The following Inspection Protocols were used during this inspection:

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **3 VPC(s)**
- **3 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	Legendé 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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident.
O. Reg. 79/10, s. 24 (3).

s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

s. 24. (7) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's care plan and have convenient and immediate access to it. O. Reg. 79/10, s. 24 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care plan sets out clear directions to staff and others who provide direct care to the resident.

Inspector #196 observed resident #001 seated in their wheelchair with a front closing seat belt and a rear closing seat belt in place.

The Inspector reviewed the health care records for information regarding the use of the seat belts. The 24-hour admission care plan indicated that a seat belt on the chair was to be used for safety, there was a hand written note to use a "FF seat belt" (Front Facing), under the category of safety, restraint use was not identified. The physician's orders included back closing seat belt restraint. The 24-hour admission care plan, under the category of safety, where restraint use would be identified, was not checked off nor hand written information included to indicate restraint use even through there was a physician's order for a restraint.

The Inspector conducted an interview with PSW #108 who reported that resident #001 had a front closing seat belt and thought that it was a restraint.

The Inspector conducted an interview with PSW #109 who reported that resident #001 had a front closing seat belt and a rear closing seat belt. [s. 24. (3) (b)]

2. Inspector #196 observed resident #003 seated in their wheelchair with a front closing seat belt in place across waist.

Inspector reviewed the health care records for resident #003 for information regarding the use of the front closing seat belt. The current physician's orders included an order for a front closing lap belt restraint. The 24-hour admission care plan, under the category of safety, where restraint use would be identified, was not checked off nor handwritten information included to indicate restraint use even though there was a physician's order for a restraint.

Inspector conducted an interview with PSW #108 and they reported that resident #003 had a front closing seat belt but they were unsure if it was a restraint. [s. 24. (3) (b)]

3. Inspector #196 observed resident #006 seated in their wheelchair with two specific types of restraint devices in place and a front closing seat belt, all of which the resident could not remove. The two specific types of restraint devices and the seat belt were confirmed by PSW #115.

Inspector reviewed the health care records for resident #006. The current physician's orders included the two specific restraint devices. The 24-hour admission care plan, under the category of safety, where restraint use would be identified, only indicated that the resident had one specific type of restraint device, not two, and did not indicate the use of a front closing seat belt. [s. 24. (3) (b)]

4. Inspector #196 observed resident #007 seated in their wheelchair with a rear closing seat belt and a front closing seat belt.

Inspector interviewed PSW #115 who reported they were unaware that resident #007 had a rear facing seat belt, and were only aware of the front closing seat belt.

Inspector #196 reviewed the health care records for resident #007. The current physician's orders included an order for a rear closing seat belt restraint for safety. The 24-hour admission care plan, under the category of safety, where restraint use would be identified, was not checked off nor hand written information included to indicate restraint use. [s. 24. (3) (b)]

5. The licensee shall ensure that the care set out in the care plan was provided to the resident as specified in the plan.

Inspector #196 observed resident #001 seated in their wheelchair with a front closing seat belt and a rear closing seat belt, both were not applied properly. The resident was observed over a period of 10 minutes and was witnessed to maneuver out of the

front closing seat belt. The rear closing seat belt remained in place around their waist.

Inspector reviewed the health care records for resident #001. The 24-hour admission care plan included under the category of mobility, had a check mark beside "seat belt on chair for safety" and hand written information of "FF seat belt" (front facing).

At 1800hrs, RPN #106 and PSW #107 were observed to approach resident #001 for a particular task and neither staff identified that the front closing seat belt was no longer in place around the residents waist until it was brought to their attention by the Inspector. [s. 24. (6)]

6. The licensee failed to ensure that the care set out in the care plan was provided to the resident as specified in the plan.

Inspector #196 observed the dinner meal service on a specific home area.

Inspector observed resident #001 receive their entree at 1710hrs and they did not attempt to feed themselves. The resident sat in their wheelchair and looked around the dining room and no staff were observed to assist the resident with the meal. Dietary staff were observed to ask the resident at 1730hrs if they were done eating and then removed the untouched plate after the resident stated they didn't want it.

Inspector reviewed the 24-hour admission care plan for resident #001 which indicated under the category of assistance required with eating, that they needed to be fed by staff and to have supervision. [s. 24. (6)]

7. The licensee failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the resident's care plan and have convenient and immediate access to it.

During the inspection, Inspector #196 conducted an interview with PSW #113 and #114 and they both reported that they had not reviewed the 24-hour care plans for their assigned residents as they did not have time at the start of their shifts. [s. 24. (7)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: 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. (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:
2. That staff apply the physical device in accordance with any instructions specified by the 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Inspector #196 conducted an interview with PSW #114 regarding resident #005. They reported that this resident had a restraint in place, front closing seat seat belt.

Inspector observed resident #005 and they were unable to remove the front closing seat belt when asked.

Inspector reviewed the health care records of resident #005 and the 24-hour admission care plan did not indicate the use of a seat belt or the use of a restraint. The current physician's orders did not include an order for the use of a seat belt restraint. [s. 110. (2) 1.]

2. The licensee failed to ensure that the following requirements were met where a resident is being restrained by a physical device under section 31 of the Act: That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

Resident #001 was observed in their wheelchair with a rear closing seat belt and a front closing seat belt and both were not applied correctly.

The Inspector brought this to the attention of RN #103 and they confirmed that the rear closing seat belt was not applied correctly.

The Inspector reviewed the current physician's orders and it identified the use of a back closing seat belt as a restraint device while resident #001 was in their wheelchair. [s. 110. (2) 2.]

3. Inspector #196 observed resident #004 seated in their wheelchair with a rear closing seat belt that was not applied correctly.

The Inspector conducted an interview with PSW #113 at the time of the observations and they were unaware of the concern with the placement of the restraint device. Upon questioning, PSW #114 reported to the Inspector that the seat belt was rolled up and that was a concern, but did not identify the placement of the seat belt as a concern.

The health care records for resident #004 were reviewed and included a current physician's order for rear facing seat belt in wheelchair as a restraint. [s. 110. (2) 2.]

4. Inspector #196 observed resident #007 seated in their wheelchair with a rear closing seat belt that was not applied correctly.

The positioning of the restraint was brought to the attention of PSW #115 who then repositioned the rear closing seat belt. [s. 110. (2) 2.]

5. The licensee failed to 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: Consent.

Inspector #196 observed resident #001 seated in their wheelchair with a rear closing seat belt and a front closing seat belt in place.

The Inspector reviewed the health care records for resident #001. The physician's orders included a back closing seat belt restraint. The consent for use of a restraint device by the Substitute Decision Maker (SDM) was not documented.

The Inspector conducted an interview with RN #103 and they confirmed that the restraint device consent form had not been signed. [s. 110. (7) 4.]

6. Inspector #196 observed resident #002 seated in their wheelchair with two specific types of restraint devices in place.

Inspector reviewed the health care records for resident #002. The current physician's orders included the two specific restraint devices. The consent from the SDM for the use of these two specific restraint devices was not documented. [s. 110. (7) 4.]

7. Inspector #196 observed resident #003 seated in their wheelchair with a front closing seat belt.

Inspector reviewed the health care records for resident #003. The current physician's orders included a front closing lap belt, as a restraint.

Inspector conducted an interview with RN #112 who confirmed that consent from the SDM for the use of a restraint device was not documented. [s. 110. (7) 4.]

8. Inspector #196 observed resident #006 seated in their wheelchair with two specific restraint devices in place and a front closing seat belt, as was confirmed by PSW

#115.

Inspector reviewed the health care records for resident #006. The current physician's orders included an order for the two specific restraint devices. The consent from the SDM for the use of a restraint device did not include both devices. [s. 110. (7) 4.]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002,003

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules are complied with: All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the inspection, Inspector #196 observed two doors on the main floor of the home, which led to non-residential areas, open and unlocked. No staff members were observed in the area of the unlocked and open doors.

After a period of approximately ten minutes, a security officer #104 was questioned by the Inspector regarding the unlocked and open doors and they reported that they didn't think they had to be locked.

During an interview with management #105 and RN #103 they confirmed that these two doors must be kept closed and locked. [s. 9. (1) 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 that ensures that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of, three meals daily.

Inspector #196 observed the dinner meal service on a specific home area.

The Inspector reviewed the dining room seating plan at 1725hrs and determined that one resident was not seated at a particular table, and questioned the staff that were present as to this resident's whereabouts. At the same time, the dietary aides were observed to remove the food from the servery counter into carts as all residents that were seated in the dining room had been served their entree. When the dietary aide overheard the Inspector asking about the resident that was absent from a particular table, they stopped removing the food from the counter. RPN #106 then reported to the Inspector that resident #008 had information in their plan of care about meals. During an interview with PSW #107, they stated that another PSW was providing care for resident #008 and was to arrange a meal plate and assist the resident in their room for the dinner meal.

At 1730hrs, dietary aide #116 then prepared a plate according to the dietary reference sheet and asked the Inspector if two plates with the meal choices should be offered to resident #008.

At 1735hrs, Inspector observed a PSW staff member take a tray with two covered entrees to resident #008 and provide them with their dinner meal service. It wasn't until the Inspector determined the resident's absence from the dining room, that the dinner meal was prepared and provided. [s. 71. (3) (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 that ensures that each resident is offered a minimum of, three meals daily, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; and the protections afforded by section 26.

Inspector #196 conducted an interview with RN #103. They reported that they started in the position working evening shifts three days prior to being interviewed and they were there to support the staff, the RNs and the management. In addition, RN #103 stated that they did not have experience working in long-term care. When questioned regarding training that had been provided prior to starting in their position, RN #103 identified that they had not received training in the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports to the Director nor the whistle blowing protection. [s. 76. (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 that ensures all staff, before performing their responsibilities at the home, receive training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; and the protections afforded by section 26, to be implemented voluntarily.

Issued on this 25 day of February 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : LAUREN TENHUNEN (196) - (A1)

Inspection No. / No de l'inspection : 2016_246196_0002 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 001797-16 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Feb 25, 2016;(A1)

Licensee / Titulaire de permis :
ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251,
THUNDER BAY, ON, P7B-5G7

LTC Home / Foyer de SLD :
HOGARTH RIVERVIEW MANOR
300 LILLIE STREET, THUNDER BAY, ON,
P7C-4Y7

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Meaghan Sharp

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To ST. JOSEPH'S CARE GROUP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and
(b) clear directions to staff and others who provide direct care to the resident.
O. Reg. 79/10, s. 24 (3).

Order / Ordre :

The licensee shall ensure that the 24-hour admission care plan sets out clear directions to staff and others who provide direct care to the resident.

The licensee shall:

(A) ensure the 24-hour admission care plans and subsequent plans of care for residents in the home, set out clear directions to staff.

(B) ensure that the information regarding restraint use is clearly indicated on these plans under the applicable category.

(C) provide training to those staff who are completing the 24-hour admission care plans to ensure resident information is accurate.

Grounds / Motifs :

1. The licensee failed to ensure that the care plan set out clear directions to staff and others who provide direct care to the residents.

Inspector #196 observed resident #007 seated in their wheelchair with a rear closing seat belt and a front closing seat belt.

Inspector interviewed PSW #115 who reported they were unaware that resident #007 had a rear facing seat belt, and were only aware of the front closing seat belt.

Inspector #196 reviewed the health care records for resident #007. The current physician's orders included an order for a rear closing seat belt restraint for safety. The 24-hour admission care plan, under the category for safety, where restraint use would be identified, was not checked off nor hand written information included to indicate restraint use.
(196)

2. Inspector #196 observed resident #006 seated in their wheelchair with two specific types of restraint devices in place and a front closing seat belt, all of which the resident could not remove. The two specific types of restraint devices and the seat belt were confirmed by PSW #115.

Inspector reviewed the health care records for resident #006. The current physician's orders included two specific types of restraint devices. The 24-hour admission care plan, under the category of safety, where restraint use would be identified, only indicated that the resident had one specific type of restraint device and did not indicate a front closing seat belt.
(196)

3. Inspector #196 observed resident #003 seated in their wheelchair with a front closing seat belt.

Inspector reviewed the health care records for resident #003 for information regarding the use of the front closing seat belt. The current physician's orders included an order for a front closing lap belt restraint when in wheelchair for safety. The 24-hour admission care plan, under the category of safety, where restraint use would be identified, was not checked off nor handwritten information included to indicate restraint use even though there was a physician's order for a restraint.

Inspector conducted an interview with PSW #108 and they reported that resident #003 had a front closing seat belt but they were unsure if it was a restraint. (196)

4. Inspector #196 observed resident #001 seated in their wheelchair with a front closing seat belt and a rear closing seat belt in place.

The Inspector reviewed the health care records for information regarding the use of the seat belts. The 24-hour admission care plan indicated that a seat belt on the chair was to be used for safety, there was a hand written note to use a "FF seat belt" (Front Facing), under the category of safety, restraint use was not identified. The physician's orders included back closing seat belt restraint. The 24-hour admission care plan, under the category of safety, where restraint use would be identified was not checked off nor hand written information included to indicate restraint use even though there was a physician's order for a restraint.

The Inspector conducted an interview with PSW #108 who reported that resident #001 had a front closing seat belt and thought that it was a restraint.

The Inspector conducted an interview with PSW #109 who reported that resident #001 had a front closing seat belt and a rear closing seat belt.

The determination to issue a Compliance Order was based upon the severity of potential for harm and the scope was a pattern. The compliance history indicated that there was previously issued unrelated non-compliance in past inspections.

(196)

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

Mar 31, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
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. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
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. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall ensure that staff only apply restraint devices in accordance with any instructions specified by the physician or registered nurse in the extended class. If there are no instructions, ensure restraints are applied according to Best Practice Guidelines.

Grounds / Motifs :

1. The licensee failed to ensure that the following requirements were met where a resident is being restrained by a physical device under section 31 of the Act: That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

Inspector #196 observed resident #007 seated in their wheelchair with a rear closing seat belt that was not applied correctly.

The positioning of the restraint was brought to the attention of PSW #115 who then repositioned the rear closing seat belt.

(196)

2. Inspector #196 observed resident #004 seated in their wheelchair with a rear closing seat belt that was not applied correctly.

Inspector conducted an interview with PSW #113 at the time of the observation and they were unaware of the concern with the placement of the restraint device. Upon questioning, PSW #114 reported to the Inspector that the seat belt was rolled up and that was a concern, but did not identify the placement of the belt as a concern.

The health care records for resident #004 were reviewed and included a current physician's order for rear facing seat belt in wheelchair as a restraint. (196)

3. Resident #001 was observed in their wheelchair with a rear closing seat belt and a front closing seat belt that was not applied correctly.

The Inspector brought this to the attention of RN #103 and they confirmed that the rear closing seat belt was not applied correctly.

The Inspector reviewed the current physician's orders and it identified the use of a back closing seat belt as a restraint device while resident #001 was in their wheelchair.

The determination to issue a Compliance Order was based upon the severity of potential for actual harm and the scope was a pattern. The compliance history indicated that a VPC was previously issued in inspection # 2014_333577_0012 dated June 15, 2015. (196)

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

Mar 31, 2016(A1)

Order # /
Ordre no : 003

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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:

1. The circumstances precipitating the application of the physical device.
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.
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. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee shall ensure that there is documented consent for restraint use.

Grounds / Motifs :

1. The licensee failed to 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: Consent.

Inspector #196 observed resident #006 seated in their wheelchair with two specific restraint devices in place and a front closing seat belt as was confirmed by PSW #115.

Inspector reviewed the health care records for resident #006. The current physician's orders included an order for the two specific restraint devices. The consent from the Substitute Decision Maker (SDM) for the use of a restraint device did not include both devices.

(196)

2. Inspector #196 observed resident #003 seated in their wheelchair with a front closing seat belt.

Inspector reviewed the health care records for resident #003. The current physician's orders included a front closing lap belt as a restraint.

Inspector conducted an interview with RN #112 who confirmed that consent from the SDM for the use of a restraint device was not documented. (196)

3. Inspector #196 observed resident #002 seated in their wheelchair with two specific types of restraint devices in place.

Inspector reviewed the health care records for resident #002. The current physician's orders included the two specific restraint devices. The consent from the SDM for the use of these two specific restraint devices was not documented. (196)

4. Inspector #196 observed resident #001 seated in their wheelchair with a rear closing seat belt and a front closing seat belt in place.

The Inspector reviewed the health care records for resident #001. The physician's orders included a back closing seat belt restraint. The consent for use of a restraint device by the SDM was not documented.

The Inspector conducted an interview with RN #103 and they confirmed that the restraint device consent form had not been signed.

The determination to issue a Compliance Order was based upon the severity of potential for actual harm and the scope was a pattern. The compliance history indicated that a VPC was previously issued in inspection # 2014_333577_0012 dated June 15, 2015. (196)

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

Mar 31, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Health Services Appeal and Review Board and the Director

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

Ordre(s) de l'inspecteur

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

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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Ordre(s) de l'inspecteur

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

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 25 day of February 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LAUREN TENHUNEN

Service Area Office /
Bureau régional de services : Sudbury