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 sous la Loi de 2007 sur les foyers de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 25, 2015	2015_285546_0012	O-002162-15	Resident Quality Inspection

Licensee/Titulaire de permis

DEEP RIVER AND DISTRICT HOSPITAL
117 BANTING DRIVE DEEP RIVER ON K0J 1P0

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

THE FOUR SEASONS LODGE
117 BANTING DRIVE DEEP RIVER ON K0J 1P0

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

SUSAN WENDT (546), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): on site on May 25, 26, 27, 28, 29, June 1, 2, 3, 4, 5, 2015

Inspection for Log O-001822-15 occurred during this RQI period.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, members of the combined Residents/Family Council, the Chief Executive Officer (CEO), the Administrator (Chief Nursing Officer), the Director of Care (DOC) (also known as Manager of Nursing Services), the RAI Coordinators, the Accounts Receivable Manager, the Programs/Recreation person, the Support Services Manager, a Maintenance person, a Housekeeping aide, dietary aides, the Infection Control Lead, the Educator, several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), one Physiotherapist and the Manager for Information Technology (IT).

In addition, the inspectors toured residential and non-residential areas, observed resident care, observed meals and snacks' services, reviewed several of the Home's policies and procedures, observed a medication pass including the medication room and medication drug destruction and reconciliation, observed recreation activities and exercise activities, reviewed minutes for the combined Residents/Family Council, reviewed Residents' Health Records including plans of care, medication and treatments records, as well as Resident Assessment Instruments of the Minimal Data Set (RAI-MDS), Resident Assessment Protocols (RAPs). Medication Administration Records (MARs) and Treatment Administration Records (TARs), PSW Point of Care (POC) documentation, reviewed recreation calendars, reviewed staffing schedules, reviewed training programs and reviewed housekeeping routines.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

- **10 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	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. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to the outside of the home, other than doors leading to a secure outside area, must be equipped with an audible door alarm that allows calls to be canceled only at the point of activation with a manual reset switch at each door.

On May 25, 2015, Inspector 547 conducted the initial tour of the Home for the Resident Quality Inspection and noted that the main double doors to the home from the Deep River Hospital Emergency Department, as well as another set of double doors inside the LTC Home immediately to the left from the main entrance doors leading to the Hospital's medical unit, were equipped with an audible door alarm. It was noted that this door

alarm was connected to an audio-visual enunciator located inside the nurses' station nearest to these doors, however, neither set of doors required a manual reset for these alarms as the alarm de-activated once the doors closed.

On May 26, 2015, RPN S#103 indicated to Inspector 547 that these doors had alarms that sounded at the nursing station and that the alarm turned off immediately when the doors were closed.

On May 26, 2015, Inspector 547 interviewed Activation Aide S#101 who indicated that the audio-visual enunciator panel in the nurses' station had buttons associated to each door in the Home. Through testing, it was determined that when a door opened and was sounding an alarm, the alarm could be canceled by pressing the associated button on the audio-visual enunciator panel.

On May 27, 2015, the DOC indicated during an interview with Inspector 547 that she was not aware that alarms had to be manually reset at each door leading outside the Home, nor that the nurses' station audio-visual enunciator panel had the capacity to inactivate the alarms. This did not comply with the requirement that door alarms only be canceled at the point of activation as the intention of the requirement for the manual reset switch at each door, was to have these alarms canceled by a person, who could verify that there had not been any unintended exit of any resident through this door.

The DOC confirmed that a work order and quotes to fix the alarm system had been initiated and that no risk was identified with the LTC residents in the Home during the time of our inspection. The LTC home agreed to continue to monitor the residents until these doors were in compliance.[547] [s. 9. (1) 1. iii. B.]

2. The licensee has failed to ensure that 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 supervised by staff.

On May 25, 2015, during the initial tour of the home for the Resident Quality Inspection, Inspector 547 noted a door off the dining room was unlocked that lead inside the home's kitchenette. Within this kitchenette, there was another unlocked door that led to a hospital hallway outside of the LTC home. This hospital hallway led to the Emergency Department's patient waiting room, as well as several unlocked and unattended doors leading to different hospital departments, including one for the main Emergency Department Building exit that was not locked.

On May 27, 2015, Inspector 547 interviewed the DOC regarding this kitchenette door to a non-residential area that once again was not closed, locked nor attended by any staff members at this time. The DOC indicated that it was the home's expectation to have the kitchenette door closed and locked at all times when unattended by staff for resident safety. [547] [s. 9. (1) 2.]

3. The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

On May 25, 2015, Inspector 547 conducted the initial tour of the Home for the Resident Quality Inspection (RQI) and noted that the Home had two separate doors leading to the secured outside garden area of the Home.

On June 2, 2015, Inspector 547 interviewed S#101 who indicated that these doors were locked and alarmed. S#101 noted that the door to the secured outside area near the barbecue was not alarming as it should be when the door was propped open. S#101 indicated that the Home did have activities where they propped the door open, to allow residents to go in and out of the Home to the garden area to sit and staff would turn off the alarm for this door at the nursing station. S#101 indicated that she was not aware as to why this door currently had the alarm disabled and that she was not aware of any process related to the patio doors to the locked outside area.

Inspector 547 interviewed the DOC regarding these patio doors, and indicated that she had verified with the Administrator and confirmed that the Home did not have a policy regarding when these doors could be unlocked and then re-locked. [547] [s. 9. (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 that all doors leading to the outside of the home, other than doors leading to a secure outside area, be equipped with an audible door alarm that allows calls to be canceled only at the point of activation, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used for Resident #008, that the resident and her bed system were not evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize the entrapment risk to Resident #008.

On May 26, 2015, Inspector 547 observed Resident #008's bed to have a four split rail system, with full rail bumper pads attached on both sides of the bed, thereby yielding an 8-inch expandable gap in the middle of each side between the split rails. Inspector 547 interviewed RPN S#103 regarding the purpose of the bumper pads utilized on Resident #008's bed; S#103 indicated the bumper pads were applied to the bed to keep Resident #008 safely in bed, as the resident had fallen out of bed in April, 2015.

On May 29, 2015, Inspector 547 interviewed the DOC in regards to the bumper pads that were added to Resident #008's bed; the DOC indicated that they added the bumper pads to prevent the resident from falling out of bed. The Administrator and DOC agreed to order full rail bumper pads for the resident in order to close the gap between the split rails on both sides of the bed. The bumper pads' purpose was to restrain the resident in bed to prevent falls. No bed assessments regarding potential zones of entrapment had been conducted in the Home to this date. [s. 15. (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 that when and where bed rails are used, residents of the Home are to be assessed to ensure that their bed systems are evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize the entrapment risk, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 52 (1) and (2), whereby the licensee did not ensure that the Pain management program was complied with.

In accordance with O. Reg 79/10, s. 30 (1) 1, s. 30 (1) 3 and O. Reg. 79/10, s. 48 (1) 4, s. 48 (2), the licensee is required to have a pain management program that includes a written description of the program that includes goals, objectives and relevant policies, procedures and protocols and provides methods for communicating and assessing residents who are unable to communicate their pain or who are cognitively impaired, strategies to manage pain and monitoring of residents' responses to and the effectiveness of the pain management strategies, using clinically appropriate assessment instruments.

During this inspection, LTCH Inspectors 546 and 547 reviewed 1 resident who complained of pain and 2 residents whose quarterly RAI-MDS assessments triggered worsening pain (from moderate intensity to severe intensity) during observation periods for their assessments.

A review of Resident #005's plan of care and triggered RAPs items by Inspector 546 on May 29, 2015, following the initial interview with the resident where he/she indicated having pain and the medication not working, revealed the resident was coded in the RAI-MDS has experiencing pain less than daily of moderate intensity, whereby the RAPs notes indicated that the resident had complained on only one occasion in the observation period, that he/she had pain. When speaking with Resident #005, the resident reported that although he/she was on regular analgesic medication, he/she still felt moderate pain frequently throughout the day; in reviewing the April and May 2015 MARs, the resident received an additional 12 doses of PRN analgesics. When asked how the registered nursing staff would measure the pain and how frequently they would assess it, Resident #005 reported not knowing about this, that he/she only reported he/she had pain and there were no other questions asked. In reviewing Resident #005's plan of care, Inspector 546 was unable to locate any pain assessment tools.

On May 29, 2015, Inspector 547 reviewed Resident #008's health record, whereby the most recent MDS triggered incidence of worsening pain. Resident #008 was taking regular pain medication daily and as required. The resident had taken an additional analgesic twenty seven times in April, and eleven times in May, 2015.

On June 1, 2015, Inspector 546 reviewed Resident #004's health record, whereby the previous to most recent MDS had triggered an incidence of worsening pain, however, no

pain assessment was conducted upon admission. The plan of care and MARs indicated that Resident #004 was taking regular analgesics daily and as required; Resident #004's pain appeared to be well controlled as the resident expressed. Despite the MDS coding, Resident #004 did not require any additional medications.

On June 2, 2015, Inspector 547 noted that Resident #008 did have a quarterly RAI assessment summary, based on the medication review of PRN usage, and response to medications, however, RPN S#104 indicated upon review of Resident #008's health records, that he/she had not had any pain assessments conducted.

In reviewing the plans of care for each resident, the inspectors could not locate any pain assessment instruments or tools, nor any re-assessment instruments or tools to measure the level or intensity of pain. Despite the lack of assessments, the registered nursing staff documented efficacy and effectiveness for the pharmacological pain strategies implemented, thereby indicating that the 3 residents had effective pain control interventions.

Inspectors 546 and 547 independently interviewed RPN S#103 and RPN S#104 who both indicated that the Home did not have any pain management program that they were aware of. In an interview with the DOC on June 2, 2015, she confirmed to the inspectors that the Home did not have pain assessment tools developed, nor a program for pain management to monitor residents' responses to and the effectiveness of pain management strategies. [s. 52.]

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 by developing a pain management program that includes the criteria established in the legislation, to be implemented voluntarily.

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:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided in the regulations O.Reg. 79/10, s. 221.

In accordance with LTCHA, 2007, c. 8, s. 76 (1), s. 76 (2) 6. and s. 76 (4) and O.Reg. 79/10, s. 219. (1), all staff are to receive training before performing their responsibilities, and annually thereafter.

Persuant to the legislation, all staff at the Home including those working in the Home pursuant to a contract/agreement, must receive training as required by this section specifically but not limited to the following area:

-All staff who provide direct care to residents shall receive training in the application, use and potential dangers of these physical devices for staff who apply physical devices or who monitor residents restrained by physical devices, prior to performing their responsibilities and annually thereafter.

In accordance with LTCHA 2007, s.76 (7) 6 and O.Reg 79/10, s. 221.(1) and s. 221 (2) 1 , all staff who provide direct care to residents shall receive, as a condition of continuing to have contact with residents, annual training specifically but not limited to:
1. Falls prevention and management
2. Skin and wound care
3. Continence care and bowel management
4. Pain management
5. Application, use and potential dangers of physical devices
6. Application, use and potential dangers for PASD's as indicated in O.Reg. 79/10, s. 221.(1).

On June 3, 2015, Inspector 547 interviewed Staff members S#101, S#103, S#104,

S#112, S#115 and S#116 who all indicated they had attended a skills day in the Fall 2014; all staff indicated being provided with a "Passport to Learning" by the Education Coordinator last Fall via a Champlain LHIN's Learning Management System (LMS). The same staff members indicated they were never able to do any of the online training required by the passport to learning as they were not able to log onto the learning management system.

S#112 and S#116 reported this to the IT department for the Home.

On June 4, 2015, Inspector 547 interviewed the IT Manager who indicated to Inspector 547 that the Champlain LHIN's LMS never functioned properly and that he reported this to the Home's Administrator last Fall, but he could not recall the exact date. The IT Manager further indicated that prior to this date, the Home had their mandatory training offered as education in classrooms.

On June 4, 2015, Inspector 547 interviewed the DOC regarding training provided for resident care staff of the LTC Home for 2014. The DOC indicated that if the staff members did not do the passport to learning modules, that the only training provided by the Home to staff who provide resident care would have been conducted on the mandatory skills days in October and November 2014. [547] [s. 76. (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 to ensure that all LTC Home staff receive training and retraining of the areas mentioned in accordance with 2007, c. 8, s. 76 (1), s. 76 (2) 6. and s. 76 (4) and O.Reg. 79/10, s. 219. (1) and s. 221 at the required intervals, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is posted in the Home, in a conspicuous and easily accessible location, in a manner that complies with the requirements, if any, established by the regulations.

On May 25, 2015, Inspector 547 conducted the initial tour of the Home for the RQI inspection, whereby it was noted that, in accordance with section 79 of the Act, the Home did not have the following required information posted:
• The LTC Home's policy to promote zero tolerance of abuse and neglect of residents.
• The LTC Home's procedure for initiating complaints to the licensee
• The notification of the LTC Home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained.
• An explanation of the measures to be taken in case of fire.
• An explanation of evacuation procedures.
• Copies of the inspection reports from the past two years for the LTC Home.

On the above date, Inspector 547 observed a posted complaints procedure indicating that any complaint could be made to the Chief Nursing Officer (CNO), however the name provided was the Home's previous CNO, who no longer worked in the Home.

On June 4, 2015, Inspector 547 interviewed the DOC who confirmed that previous CNO left the Home approximately in February 2014.

On June 4, 2015, Inspector 547 interviewed RPN S#104 who indicated that the above items were not posted anywhere else in the home. [s. 79. (3)]

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 posting of the required information, as established in section 79 of the Act and sections 224, 225 of the Regulations are regularly reviewed and complied with, to be implemented voluntarily.

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. 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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The license has failed to ensure that the staff apply Resident #001's physical device in accordance with the manufacturer's instructions, in respect to the restraining of a resident by a physical device under section 31 of the Act.

On May 26, 2015, Inspector 546 observed Resident #001 sitting in a tilt wheelchair with a loosely applied lap belt, covered by a black sock. The inspector was able to insert a full hand length (approximately a 4 inches gap) between the resident and the frog clip lap belt. During the first week of the RQI inspection, specifically on May 27, 28, 29, 2015, the inspector observed the same loose application of the lap belt; the PSW staff indicated that the lap belt was always applied in that manner, when the inspector asked if this was the correct way to apply the lab belt.

A review of the plan of care revealed no manufacturer's instructions for the lap belt nor

specific instructions in the correct application of Resident #001's lap belt restraint when the new tilt chair was delivered on March 27, 2014; the care plan or progress notes at that time did not outline specific steps for when the resident was to be monitored, nor who or what was to be observed, nor did it specify the how-to steps for releasing the restraint and repositioning Resident #001 every 2 hours or more frequently. On July 14, 2014, RPN S#103 documented in the progress notes that a message had been left for the OT to discuss the frog clip on the resident's chair; a verbal consent was obtained from the spouse to obtain the new frog clip lap belt. In a progress note entry on August 15, 2014, RPN S#103 documented speaking with resident's spouse about the frog clip belt and the spouse's wishes were to keep the belt on.

On May 29, 2015, in an interview with Inspector 546, Resident #001's spouse indicated that the lap belt was to prevent falls and explained that the black sock over the lap belt clip was to prevent the resident from undoing the clip, stating that he/she was fidgeting with the clip. When Inspector 546 noted that a loose lap belt could increase the risk for falls or choking, the spouse indicated that it was more comfortable for the resident and only served as a reminder. When asked if other alternatives were ever suggested or recommended, the spouse replied no, I guess this is the best alternative.

During an interview with RPN S#104 on June 1, 2014, she confirmed that there were no manufacturer's instructions; she indicated that the chair had originally arrived with a regular standard buckle seat belt as consented by the spouse, but since Resident #001 constantly was fidgeting with it, the family was worried about the resident undoing the belt and falling. She added that the Physiotherapist had recommended a frog clip lap belt. On June 3, 2015, RPN #104 indicated that the lap belt was applied differently and inconsistently by everyone providing care to Resident #001.

During the daytime on June 1, 2, 3, 2015, Inspector 546 observed Resident #001 in the tilt wheelchair with the lap belt in the same loose application, covered by the black sock. The resident, who was not moving or fidgeting, was either accompanied by the spouse or was in constant view of staff in the lounge and dining area. [s. 110. (1) 1.]

2. The licensee has failed to ensure that Resident #009 was reassessed for the effectiveness of the restraining by a seat belt while in a wheelchair at least every eight hours, and at any other time based on the resident's condition or circumstances been reviewed to be effective and necessary for the resident's safety.

On May 26, 2015, Inspector 547 noted that Resident #009 was seated in a wheelchair,

with a seat belt applied that was not properly adjusted for the resident. The resident's spouse was seated next to the resident, who indicated that the resident no longer required the seat belt, as he/she no longer moved or walked any longer. The resident's spouse indicated that it is applied only as a precautionary measure. The resident's spouse further indicated that he/she has never been asked to review the need for the seat belt to this date.

On June 2, 2015, Inspector 547 interviewed RPN S#119 who indicated that Resident #009 used to move quite a bit while in the wheelchair, and at that time was at risk of falls; she further indicated that Resident #009 had declined and no longer needed the seat belt as the resident rarely independently moved any longer, and likely needed to be re-assessed.

On June 5, 2015, Inspector 547 interviewed the DOC, who indicated that all residents should be reassessed for their need of restraints, and discontinued when they no longer required them. [s. 110. (2) 6.]

3. The licensee has failed to ensure that the restraints release and repositioning documentation included every release of restraint devices and repositioning.

On May 26, 2015, Inspector 547 interviewed PSW S#102 regarding who documented the resident's release and repositioning when residents are restrained; S#102 indicated that Registered Nursing staff record this information.

On June 2, 2015, Inspector 547 interviewed RPN S#104 regarding the documentation of every release of restraint devices in the home and the repositioning of these residents. S#104 indicated that Registered Nursing staff document the release of every restraint device and the repositioning of residents once per shift. S#104 indicated that the registered staff usually ask PSWs to reposition the residents every 2 hours, and either registered nursing staff or PSW monitor the residents restraint hourly. S#104 indicated that the Home only expects Registered Nursing staff to sign once per shift.

Inspector 547 reviewed the Home's restraint policy R-035 titled Restraints-Minimizing Restraining of Residents-use of Restraints with a review date of July 2011. On page 5 of 10 of this policy, it indicated the care plan is to authorize staff to:
• outline specific steps for monitoring the resident at a minimum hourly by Registered Nursing staff or a person who is authorized by Registered Nursing staff), specifying who, when and what to observe and document.

• outline steps for releasing and repositioning the resident at least every 2 hours, and to specify how this will be done.

On the same page of said policy, the implementation of this plan indicates:
• Document every hour on restraint monitoring record and every 2 hours when the restraint is released and the resident is repositioned and care plan interventions have been followed.

S#104 indicated that the Home had been using the restraint monitoring record a long time ago, but no longer used this form since the Home implemented the electronic documentation system for progress notes, MARs and TARs two years ago. The current electronic MARs and TARs documentation only indicated a signature every shift to indicate that this activity occurred for restraints, but did not identify who monitored, or who repositioned the resident and what was done as per their own policy.

S#104 further indicated that their policies and procedures needed to be updated and revised when the Home implemented the electronic documentation system, but this has not been done since July 2011. [s. 110. (7) 7.]

4. The licensee failed to ensure that, for every release of the physical device used to restrain Resident #001 and for all repositioning, is documented as per O. Reg. 79/10 s. 110 (7) 7.

In accordance with s. 31. (1) of the Act, 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 plan of care and furthermore, only if all provisions identified in subsection 30 (2) are satisfied and requirements under subsection 30 (3) are met.

The Home's Policy R-035, Restraints - Minimizing Restraining of Residents: Use of Restraints clearly identifies in the Care Plan section (page 4 of the Policy), all of the provisions and requirements stipulated in the Act. The policy goes on further to stipulate under the Implement section of the policy, point 2 (on page 5) that the interdisciplinary team "Document every hour on restraint monitoring record (Appendix C of the policy) and every 2 hours when the restraint is released and the resident is repositioned and care plan interventions have been followed."

Upon review of Resident #001's plan of care, Inspector 546 could not locate any specific steps for when the resident was to be monitored, nor who or what was to be observed,

nor did it specify the how-to steps for releasing the restraint and repositioning Resident #001 every 2 hours or more frequently. The plan of care and archived plan of care had no physical restraint monitoring record.

On June 3, 2015, in an interview with Inspector 546, RPN S#104 confirmed that there was no documentation on the paper restraint monitoring record, since the electronic documentation was initiated, but that registered staff were to record on the eMAR once per shift, every shift.

A review of Resident #001's April and May 2015 eMARs by Inspector 546 indicated that a Pharmacy pre-printed line indicates: 'Lapbelt when up. Check restraint every 1 hr and release and re-position every 2hrs'. RPN S#104 indicated that although it was signed, it may or may not have been carried out as indicated; RPN S#104 further confirmed that documentation as per policy R-035 was not accurately reflected.

On June 3, 2015, in an interview with Inspector 546, the DOC concurred that the Home's documentation for physical restraints did not follow the policy or the legislation. [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 in ensuring that a process for staff to document (every hour re: restraint monitoring and every 2 hours when a restraint is released and the resident is repositioned) is implemented and that changes to the policy and plans of care are effected and complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On May 25, 2015, during the RQI's initial tour of the Home, Inspector 547 noted the following in a basket next to the sink in the Home's shared residents' tub room: a pair of rubberized white and green set of toenail clippers labeled FSL tub room, a pair of unlabeled scissors, and an unlabeled functional electric razor. Next to the tub, was a plastic utility container with 4 drawers that contained several unlabeled combs with grey hair on them and hair curlers that were stored on top of a dried yellow sticky matter on the bottom of 2 of the 4 drawers. Inside the third drawer, there was a black bath cushion with no resident label.

On May 27, 2015, Inspector 547 interviewed PSW S#102 regarding the process for offering residents' baths. He indicated that residents in the Home are provided with a plastic container to carry their personal care items to the tub room, and returned to their room at the end of the bath. Each resident should have their own nail clippers, but these were the tub room clippers. The electric razor found in the tub room was used to trim women's whiskers following their bath. This razor was cleaned on nights, as per the schedule with the cleaning fluid found in the soiled utility room. Upon review of the soiled utility room, the yellow spray bottle identified by S#102 to be the cleaning agent, was a general all-purpose cleaner, that had a label on it for cleaning of equipment.

Interview with RPN S#104 regarding the non-labeled items located in the tub room, indicated that these items should not in there, as every resident was given a nail clipper, a comb if they need one, and that the Home provided disposable razors. The items were removed from the tub room. In the interview with PSW S#107, who provided baths to residents when assigned the bathing duty, she indicated that she did use the nail clippers when residents did not have their own, and would wash them with the yellow Virox solution used to clean the tub between residents.

On May 25, 2015, Inspector 547 observed PSW S#105 with a basket of nail supplies used for manicures. On May 27, 2015, RPN S#103 showed Inspector 547 the basket used by PSWs to give female residents a manicure. Inside the basket, were several loose nail files, including three with dried white dust matter, that S#103 indicated had been used already for a resident and should not have been returned to the basket with the clean files; she indicated that files provided by the Home were to be for single use

only.

On May 27, 2015, in an interview with Inspector 547, the DOC indicated that it was the Home's expectation that items such as nail clippers, nail files, combs, and razors, not be shared, adding that every resident should have their own as the Home supplies these. She indicated that every resident tray should have a set of nail clippers. Inspector 547 informed the DOC that upon observation of six out of six resident personal item trays, none contained any nail clippers. [s. 229. (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 to ensure that a process is developed and implemented in the proper and safe use of single-use personal care items and that no personal care items are shared among residents of the Home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any concerns, complaints or recommendations received from the Residents/Family Council was provided a written response within 10 days.

Upon review of the Residents/Family' Council meeting minutes from May 2014 to May 2015, there were no written responses provided by the licensee within 10 days to the Council for concerns, complaints or recommendations identified for the following

months:
• May 15 2104 meeting: one family member waiting for pictures of the Scottish Celebration from the CEO; the administrative assistant's office was called and the Council assistant was informed that they would look into this. Recommendation for new resident package.
• June 26 2014 meeting: no pictures or written response received re: pictures; concerns reported by families about holes in the screens of the gazebo.
• July 17, 2014 meeting: no pictures or written response received re: pictures; no written response re: gazebo screens repair - Council Assistant will request maintenance repairs or replace.
• August 21, 2014 meeting: Business Arising Minutes indicate that screen repair for the gazebo as being completed. New recommendations brought forth by a resident – to have a binder with previous Council minutes for residents to review and to having the agenda package 24hours before the Council meeting date.
• September 25, 2014 meeting: Business Arising Minutes include that a binder was created by the Council assistant and that it is kept at the communication desk. New recommendation brought forth by a resident – to have screen door in old sun room repaired, as birds are flying inside. Other: residents wishing to practice their faith, requesting rosaries.
• October 16, 2014 meeting: Business Arising Minutes indicate that the screen door in the sunroom has been fixed and that Maintenance is reconsidering a future use of the room; Council Assistant reports she has not heard from the church.
• November 19, 2014 meeting: Business Arising minutes indicate confusion re: which parish is to visit for residents practising faith (rosary prayers).
• December 18, 2014 meeting: Business Arising minutes include a new Resident Package (which originated in May 2014) item which is now closed; Council Assistant communication that religious group services to begin in January.
• January 15, 2015 meeting: Business Arising minutes indicate that residents complained of not enough heat in Four Seasons Lodge in a few bedrooms. (NOTE: DOC attended to this issue immediately (date not documented) consulting with the maintenance and that the problem was rectified. Monthly Diners' Club discussion of ongoing lack of availability to residents remains an issue.
• February 26, 2015 meeting: Business Arising minutes indicate that for the Monthly Diners Club - the DOC reported that the Administrator had made contact with an organization described only as NRLTC and expressed continued interest in residents attending the Diners' Club monthly lunch.
• March 26, 2015 meeting: Business Arising minutes indicate that North Renfrew LTC (NRLTC) will have space for Four Seasons' Lodge residents for lunch in the future.

Administrator requests that item be removed from standing agenda.
• April 16, 2015 meeting: Families and Residents request use of screen porch this year; Administrator informs residents and family she will ask the ESM to clear the screened porch of wheelchair storage. Families also request push button accessibility (for wheelchair bound residents) from the hallway back door as the door is heavy and the existing foot peg is difficult to use; the Administrator will ask the ESM to re-evaluate the back door accessibility and obtain an estimate or an alternate solution. Families complained that bathroom drains are emptying slowly and request that they be cleaned; the Administrator will notify the ESM.
• May 21, 2015 meeting: no minutes received as the time of this report.

During an interview with Inspector 546 on June 3, 2015, the Council Assistant (in the absence of the Administrator) acknowledged that responses to concerns or issues were usually provided by the next meeting verbally or indicated in the minutes of the Council's meetings; she confirmed that the agenda and Council meeting minutes are usually only available 24hrs prior to the scheduled meeting as they originate from the Administrative assistant in the Administrator's office. The Council Assistant indicated not being aware of the Duty to Respond legislation, which the licensee must complete in writing, within 10 days of receipt of a concern, issue or recommendation. [s. 60. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 64. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee has failed to ensure that it complies with LTCHA, 2007, S.O. 2007, c. 8, s. 64, whereby persons involved in the management or operation of the home attend the combined Residents/Family Council meetings regularly, without invitation.

The Home has 14 residents and a few years ago, it was decided to combine both Residents' Council and Family Council into one combined council to recognize and enhance the contribution of all residents, their advocates and/or loved ones, to prevent duplication while enhancing efficiency and minimizing the number of meetings; this is not documented in the Council minutes.

In an interview with 2 family members who attend the combined Residents/Family Council monthly meetings, both confirmed that the Administrator and the DOC attend the Council meetings regularly. Neither of the Family members could recall this being brought to their attention at Council meetings.

While reviewing the Minutes of the combined Residents/Family Council, it was noted that the Administrator/Chief Nursing Officer was present at all meetings from June 2014 onward and the Director of Care was present from November 2014 onward, with few exceptions due to other commitments.

On May 29, 2015, the Administrator confirmed to Inspector 546, that she attended all meetings of the Council and also emitted the agenda for said Council.

On June 2,2014, the Director of Care confirmed to Inspector #546 in the presence of Inspector 547 that she attended all meetings of the Council.

Upon further review of the Residents/Family Council Meetings' minutes, there was no evidence of the Council members being offered external support from resources, such as Family Councils' Program of Ontario, and to be its own lead, with support from an appointed assistant. [s. 64.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Residents/Family Council advice is sought in the development and carrying out of the satisfaction survey, and in acting on the survey's results.

Upon review of the LTCH Confirmation Checklist for Quality Improvement and Required Programs completed and signed by the Administrator on May 25, 2015, Inspector 546 noted that the licensee had confirmed "YES" answers, in writing to Questions 7, 9, 10, 11 and 12 which referred to: seeking the advice of the Residents' Council and Family Councils, in the development of the satisfaction survey, in the carrying out of the survey, and in acting on the survey's results.

The last Satisfaction survey was conducted in 2013, as indicated by the Administrator on the signed checklist.

On May 28, 2015, Resident #004 in the presence of the Family Member both indicated that they were not involved in any part of the satisfaction survey. Resident #004 has been living at the home since 2011.

On May 29, 2015, a Family Member indicated that the licensee did not involve the Residents' or Families in any part of the satisfactory survey. On June 3, 2015, the Council assistant confirmed that the licensee did not involve the Residents/Family Council in any part of the satisfactory survey.

The survey results from 2013 were not made available to Residents/Family Council, nor were they posted in the LTC Home. [s. 85.]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c. 8, s.85 (1), whereby the licensee did not ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the Home and the care,

services, programs and goods provided at the home.

In an interview with 2 family members who attend the combined Residents/Family Council monthly meetings, both confirmed not having filled out a satisfaction survey for the Home since the admission of their loved ones.

The Home's Administrator reported to Inspector 546 that the Home's last satisfaction survey was conducted in 2013. The Administrator explained that with the changes in management in 2014, the Home failed to fulfill the requirement to conduct annual satisfaction survey. The Administrator reported that the Home is planning the next satisfaction survey for the fall of 2015. [s. 85. (1)]

Issued on this 2nd day of July, 2015

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

Original report signed by the inspector.