Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Amended Public Copy/Copie modifiée du public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 11, 2019 | 2018_752627_0023 (A1) | 027786-17, 008628-18, 016380-18, 019295-18, 025765-18, 026967-18 | Complaint |

### Licensee/Titulaire de permis

Board of Management for the District of Nipissing West
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

Au Chateau
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

Amended by SYLVIE BYRNES (627) - (A1)

### Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***

**Written plan and compliance due dates required to be amended.**

**Issued on this 11st day of January, 2019 (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**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***


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

Amended by SYLVIE BYRNES (627) - (A1)

### Amended Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): November 5-9, 13-16 and 19-23, 2018.**

**A Follow Up Inspection #2018_752627_0024 and a Critical Incident System Inspection #2018_752627_0025 were completed concurrently with this Complaint Inspection. PLEASE NOTE: written notifications and Compliance Order (CO) related to LTCHA, 2007, s. 6 (7) were identified in this Inspection and have been issued in Inspection Report #2018_752627_0024.**

**The following intakes were completed in this Complaint Inspection:**

**- One log related to alleged staff to resident physical abuse;**

**- One log related to infection prevention and control;**

**- One log related to medication administration;**

**- One log related to restraints;**

**- One log related to staffing, recreation program, housekeeping, resident's Bill of Rights and training; and,**

**- One log related to plan of care not being followed, housekeeping, wounds, communication and continence care.**

**Inspector, Steven Naccarato (#744) attended this inspection along with Inspector #627.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Coordinator of Resident Services (CRS), Environmental Service Manager (ESM), Dietary Manager (DM), Physiotherapist (PT), Pastoral Care, Physiotherapist assistants (PTAs), Dietary Aides (DAs),**

**Housekeeping staff (HS), Pharmacy Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and families.**

**The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigations, policies, procedures and programs.**

**The following Inspection Protocols were used during this inspection:**

**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**

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

- **10 WN(s)**
- **3 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities**

**Specifically failed to comply with the following:**

**s. 10. (2) Without restricting the generality of subsection (1), the program shall include services for residents with cognitive impairments, and residents who are unable to leave their rooms. 2007, c. 8, s. 10 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the recreational and social activities program included services for residents with cognitive impairments and residents who were unable to leave their room.

A complaint was submitted to the Director, by resident's #003's family member, alleging that the home had no recreational activities for residents who were

cognitively impaired and resided on a specific unit.

Inspector #627 conducted two separate interviews with resident #003's family member, in which resident #003's family member became very emotional. They stated that they found the way that resident #003 was treated, to be cruel. They stated that resident #003 was restrained daily for an extended period of time. They further stated that many restrained residents sat all day long and were not provided with any form of meaningful social activities. Resident #003's family member stated that the residents were bored as they sat, restrained, with nothing to do.

Inspector #627 reviewed the activity calendar posted in the home at the time of the inspection. On the first day of the inspection, the activities listed for the home were "Resident Council meeting and Bingo". The following day, the listed activities were "Dietary Meeting, Union Cultural and Music/Ghost Rider". The Inspector had not observed any of the listed activities to have occurred on the specific unit. On a specified date, Inspector #627 observed Physiotherapy Assistant (PTA) #112 enter the specific unit and provide the six residents in the TV room, close to the nursing station, with plastic hockey sticks. Five of the six residents were observed playing "hockey" for a period of 11 minutes. Resident #004 was provided with a hockey stick, however they were unable to take part in the activity. The Inspector noted that there was no attempt to gather any other residents to take part in the activity.

Inspector #627 reviewed the home's policy titled "Adjuvant Policies and Procedures, Small Group Activities", #01-006, dated March 2017, which indicated that "small group programs and individualized activities shall be provided for those residents who are not interested or are not able to participate in larger groups. Individual activities shall be organized based on residents' wishes and capabilities".

Inspector #627 reviewed resident #003's care plan in effect at the time of the inspection which indicated for the focus of activation, that resident #003 was to attend/participate in activities of choice, a specific number of times weekly, and to provide a program of activities that was of interest and empowered resident #003 by encouraging/allowing choice, self-expression and responsibility, adapted to their capabilities. Staff were to assist/escort resident #003 to activities of choice that reflected prior interests and desired activity level. For the focus of behaviour/mood, resident #003's care plan indicated to distract the resident with a

range of activities.

Inspector #627 interviewed Personal Support Worker (PSW) #110 who stated that there was perhaps one activity per month on the specific unit, and that most of the time, the activity was manicures. They stated that it was always the same three or four ladies that took part in the manicure activity because "they were quiet and had no responsive behaviours". They further stated that there were no activities for the residents with dementia or those who exhibited responsive behaviours. PSW #110 further stated that none of the activities in resident #003's care plan were offered as PSW staff had not had the time to complete activities with the residents, and that the Recreation department staff were rarely on the unit.

Inspector #627 was approached by PSW #143 during the inspection. PSW #143 shared with the Inspector that there no longer were activities for the residents. They stated that the Recreational department was always short staffed, and the Manager continuously refused to buy supplies stating that there was no money for supplies; for example, for Halloween, oranges had been purchased to decorate instead of pumpkins as this was cheaper. They further stated that the only activities they had seen were bingo, on Friday and Monday and manicures on Fridays which were provided mostly on another floor. The weekends had no activities. PSW #143 further stated that the Manager of the Recreation department told the Adjuvants (Activity Aides) that there would no longer be one on one activities; they told us "it will never happen". PSW #143 stated that their previous Manager had made the specific unit their priority; now there were no activities on the specific unit.

Inspector #627 interviewed Activity Aide (AA) #115 who stated that the Recreation department "was going through a shuffle". A full complement of staff comprised of four full-time and one part-time employee; however, presently the department had two full-time employees, one of which was working reduced hours, one part-time employee and one casual employee. Additionally, one of the full-time employees was now completing paper work only. AA #115 stated that they had returned to work approximately a few months ago and had been made aware that the "specific unit had been hit hard" and that they were always the last to have activities. AA #115 stated that it was sad as the residents appeared so happy when someone came to the unit and sang. They further stated that most of the activities were geared towards other units, where the residents were more independent, and that the specific unit "got nothing". AA #115 shared with the Inspector that previously, the AAs had taken residents to the Snoozelin room;

however, they were told to stop, as the home had not wanted one on one activities. They insisted on group activities.

Inspector #627 interviewed the Resident Services Coordinator (RSC), who was lead for the Recreation department. They stated that there should be five AAs for the Activity program; however, the department only had three AAs for the last five to six months. They acknowledged that the specific unit, identified in the complaint, had not had many activities and that "they had been suffering for a while; however, they just didn't have the bodies". The RSC further stated that they had been told by their former Supervisor that one on one activities were not to occur and that all activities should be group activities. They further acknowledged that there were no activities for residents who exhibited responsive behaviours and advanced dementia. [s. 10. (2)]

***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**

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care included the method of restraining that was reasonable, in light of the resident's physical and mental condition that was the least restrictive method that was effective to address the risk.

A complaint was submitted to the Director regarding concerns with restraining.

A.

Inspector #627 interviewed resident #003's enacted substitute decision maker (SDM) who stated that resident #003 was being restrained, as the resident had demonstrated responsive behaviours. Resident #003's SDM stated that resident #003 became agitated due to certain triggers, which made them react. Resident #003's SDM stated that there were no activities on the unit, and the residents were bored, which caused more responsive behaviours. Resident #003's SDM stated that they were called one day by RN #119, who informing them that resident #003 had to be restrained for the safety of all residents, and that no alternatives were discussed.

Inspector #627 reviewed the home's policy titled "Minimizing Restraining of Residents and the Use of Personal Assistance Service Devices (PASDs)", last revised May 12, 2017, which indicated, to include any/all alternatives that were tried/considered and why they were not suitable. Obtain input from interdisciplinary team members (e.g. RN, RPN, PSW, Physiotherapist, Occupational therapist), to identify alternative treatment options to be tried prior to the use of restraints. Alternative treatment to restraints- a method that imposes less control on the resident than restraining or confining the resident e.g. using a monitoring/safety device on a resident to deal with incidents such as falls,

wandering, and aggressiveness were an alternate treatment intervention.

Inspector #627 reviewed a report from an outside agency, regarding resident #003. The report suggested to use restraints as an "absolute last resort".

Inspector #627 reviewed resident #003's care plan in effect at the time of the inspection which identified specific interventions for the focus of physical restraints. For the focus of behaviour, multiple interventions were listed to distract and to provide a sense of self-worth. It was also indicated to continuously try alternative interventions to restraints. For the focus of pain, an intervention listed was to encourage mobility, physical activity as tolerated. For the focus of activities, specific interventions which were to occur at specific times were identified.

Inspector #627 reviewed resident #003's progress notes from a period of five months which identified documentation of 12 instances where resident #003 had demonstrated responsive behaviours towards other residents. The last progress note identified that RN #119 had called resident #003's SDM informing them that resident #003 was to be restrained as the resident was exhibiting responsive behaviours, which may have been a danger to other residents. Specific interventions for the care of resident #003, while they were restrained, was also mentioned by RN #119.

Inspector #627 interviewed PSW #104 who stated that resident #003 was restrained as the resident exhibited responsive behaviours towards other residents and staff. PSW #104 stated that resident #003 had an intervention in place that had been effective; however, the intervention could not be continued. As well, other interventions had been trialed. PSW #104 stated that RN #119 decided who was going to be restrained.

Inspector #627 interviewed PSW #110 who stated that a specific activity was a trigger for resident #003's responsive behaviours, and since the activity occurred frequently, resident #003 was restrained. PSW #110 stated that the resident had not received the interventions listed for care while restrained due to staff workload. As well, they stated that resident #003 should be taken out of their restraint every two hours and that this had not occurred regularly due to the workloads of staff. PSW #110 also stated that none of the activities listed in the care plan had been trialed as there were no activities on the floor except for the odd manicure day and that staff (PSW) had not had the time to engage the

residents in activities. PSW #110 stated that residents in wheelchairs were never taken to activities outside of the unit unless they had a family member to take them, nor was there any trials to reduce the resident's trigger, except for leaving the resident in their room, alone and restrained. PSW #110 stated that restraining resident #003 caused them to become more agitated; PSW #110 further stated that resident #003's responsive behaviours towards others were stopped promptly and that no one had sustained injuries. PSW #104 further stated that the residents with restraints were reassessed by the RN; however, PSWs were not asked for input.

Inspector #627 interviewed RPN #107 who stated that if a resident had a lot of falls, the resident was placed in a wheelchair with an untied table top and if the resident removed the table top, then it was tied in the back. RPN #107 stated that alarms had been trialed; however, since the staff were usually in the rooms providing care, the alarms were not heard. RPN #107 stated that resident #003 was restrained due to responsive behaviours; a specific activity would trigger resident #003, and then, "the behaviours started". RPN #107 stated that the unit no longer had activities regularly, and that residents were not brought to activities outside the unit. They further stated that activities in the evening would be beneficial as this was when most of the responsive behaviours occurred.

Inspector #627 interviewed Behavioural Services Ontario (BSO) PSW who described their duties as requesting Dementia Observation System (DOS) charting to be completed to try to establish a pattern for a resident's behaviours, which they provided to the RN, who would be the one to follow up on the findings. They stated that part of their role was to make recommendations to keep the resident's hands busy, although they had not worked directly with the residents. The BSO PSW stated that they had been involved with resident #003 mostly to address a different responsive behaviour, and that they had found that specific activities were resident #003's triggers. They further stated that the resident was a "walker" and that this could not be helped and had to be stopped due to the resident's responsive behaviours. The Inspector asked if the recommendations made by the outside agency had been trialed prior to restraining the resident to which the BSO PSW stated, "not by me". They further stated that there had been no activities on the unit for "the longest time"; however, there was music playing at times on the unit.

Inspector #627 interviewed RN #129 who stated that they, and the Resident Assessment Instrument (RAI) Coordinator, had quarterly restraint meetings to

discuss what restraints were in place, how many residents were restrained, and to look at the resident's behaviour scores to see if the number of restraints used could be decreased. They stated that resident #003 was restrained due to responsive behaviours as they were a risk to themselves and others. RN #129 further stated that they had not thought that anything else was trialed prior to the restraints, and that they had not attempted to reduce the use of resident #003's restraints.

Inspector #627 interviewed RN #119 who stated that due to resident #003's responsive behaviours, they had no choice but to restrain resident #003. RN #119 stated that they had attempted redirecting, which had been effective; however, staff were not able to watch resident #003 all the time. RN #119 stated that the resident was assessed in the beginning for a lesser restraint; however, nothing else was trialed and they had not been reassessed as they were expected to be transferred soon. RN #119 stated that increased safety check was not trialed, a specific activity was not identified as a trigger, another specific intervention had been trialed; however, another resident interfered with the intervention. RN #119 further stated that the home had not had an alarming system to monitor the resident, and if they (RN #119) could have trusted resident #003, they would have assessed them for a lesser restraint, and that perhaps now, a specific intervention would be effective and they could trial a removal of the restraint.

Inspector #627 interviewed the Director of Care (DOC) who stated that resident #003 was restrained to address their responsive behaviours towards other residents. They further stated that a specific intervention had been trialed and was effective; however, this could not be sustained. The DOC stated nothing else was trialed aside from the current restraint (no lesser restraint).

B.

Inspector #627 observed resident #004 on a specific unit, with a specific restraint in place.

Inspector #627 reviewed a progress note, which indicated that resident had a certain number of falls, in a two month period. All of the resident's falls involved a specific activity of daily living (ADL). They had specific interventions in place; although, due to their health status, the resident was no longer able to complete the ADL. Resident #004 often fell and frequently, this was because resident #004

attempted to complete the specific ADL.

Inspector #627 reviewed resident #004's care plan in effect prior to the resident being restrained and noted for the focus of ADL, the care plan advised staff that resident #004 required a specific level of assistance while completing the specific ADL.

Inspector #627 reviewed resident #004's care plan for the focus of ADL after the restraint was applied which indicated that the resident required an increased level of assistance for a specific ADL and included interventions that were more restrictive to their mobility.

Inspector #627 reviewed resident #004's minimal data set (MDS) assessment (the last assessment prior to restraints being applied), which indicated that the resident required a specific level of assistance while performing a specific ADL due to responsive behaviours.

Inspector #627 reviewed resident #004's MDS assessment (after the restraint was applied), which indicated that the resident required extensive assistance and was totally dependent on staff for the specific ADL.

Inspector #627 interviewed PSW #104 who stated that they were not sure why resident #004 was restrained as the interventions were probably no longer necessary.

Inspector #627 interviewed RPN #107 who stated that they were not supposed to restrain anyone that could walk, unless there was a reason. RPN #107 further stated that if a resident had a lot of falls or an unsteady gait, the resident was sat in a wheelchair and an untied table top was applied, and if the resident removed the table top, then the table top was tied at the back.

Inspector #627 interviewed RN #119 who stated that resident #004 had a lot of falls while completing a specific ADL. They further stated that the resident had been restrained for "as long as they could remember". The RN stated that the resident had a specific intervention for falls; however, by the time staff responded, the resident had fallen. For this reason, an intervention that prevented the resident from attempting the specific ADL had been implemented. They further stated that the resident had not been assessed for a lesser restraint as seat belts that locked were no longer permitted.

Inspector #627 interviewed RN #129 who stated that resident #004 used to be ambulatory, and by applying a restraint, they were no longer able to complete a specific ADL by themselves, which reduced their risk of falls. RN #129 further stated that the restraint was to prevent the resident from completing a specific ADL and that it had "never clued in" that they may not have needed the restraint.

Inspector #627 interviewed the DOC who stated that resident #004 was restrained as they had "wobbly legs". The DOC further stated that nothing else had been trialed and that there was a decision tree to assist with the decision to restrain someone; however, it had not been utilized.

C.

During the inspection, Inspector #627 observed resident #005 with a specific restraint in place.

Inspector #627 reviewed resident #005's care plan in effect at the time of the inspection and noted for the focus of restraint that the resident was to have a specific intervention in place.

Inspector #627 reviewed resident #005's progress notes which indicated a specific number of instances whereby resident #004 had ambulating independently after removing their restraint. The resident had been unharmed.

Inspector #627 interviewed PSW #104 who stated that resident #005 was restrained; however, they no longer needed the restraint as they completed a specific ADL independently.

Inspector #627 interviewed RPN #107 who stated that resident #005 was restrained due to falls. They further stated that resident #005 previously had a specific intervention in place; however, it had failed as an intervention as staff had been busy caring for other residents. RPN #107 stated that resident #005 completed a specific ADL independently, although they were not supposed to, and that perhaps they should have been reassessed as they may no longer needed to be restrained.

Inspector #627 interviewed RN #119 who stated that resident #005 had a restraint

as they fell all the time. They further stated that a lesser restraint had not been considered.

Inspector #627 interviewed the DOC who stated that resident #005 had a specific restraint for their safety. They further stated that there was no documentation to indicate that the resident was reassessed for the use of a restraint and that usually, residents were reassessed to see if the restraint could be removed completely and not to explore for a lesser restraint. [s. 31. (2) 3.]

***Additional Required Actions:***

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

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

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**WN #3: 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:**
**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.) O. Reg. 79/10, s. 110 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident was restrained by a physical device under section 31 or section 36 of the Act, the resident was released from the physical device and repositioned at least once every two hours.

A complaint was submitted to the Director regarding concerns with restraining. Please see WN #2, item A, for details.

Inspector #627 interviewed resident #003's enacted SDM who stated that resident #003 was being restrained to keep them "out of trouble"; however, they had been told by staff members that resident was not removed from their restraint every two hours regularly, due to staffing and workload.

Inspector #627 conducted a tour of the specific unit and noted that many residents (13) were restrained with a table top attached to their wheelchair.

Inspector #627 reviewed the home's policy titled "Minimizing Restraining of Residents and the Use of Personal Assistance Service Devices (PASDs)" last revised May 12, 2017, which indicated that the Long Term Care Homes Act (LTCHA) requirements for a resident who was restrained was to have their restraint removed and the resident repositioned every two hours.

A.

On a specific date and time, during a meal service, resident #003 was observed sitting at a two person table. The resident was restrained. The resident was brought to the TV room after the meal, where they remained for a period of almost three hours. The resident was observed demonstrating a specific behaviour while restrained, until they were provided with assistance with a specific ADL.

At a later date, Inspector #627 observed resident #003 being brought to the dining room, with the restraints in place. The Inspector observed resident #003 returned to their room at a specific time, where they remained until the next meal service, when they were brought to the dining room. The resident was not repositioned or provided with continence care prior to the meal service. The resident was returned to their room, where they remained. The resident had not been repositioned or provided with continence care for a period of over four hours, when the resident was observed completing a specific ADL with a family member.

Inspector #627 reviewed resident #003's care plan in effect at the time of the inspection and noted for the focus of "physical restraint" that the resident was to have two specific restraints in place. The interventions included repositioning every two hours and the application of a restraint at all times except at meals due to having more staff in the dining room to supervise. The care plan advised staff that the resident was to be removed from their wheelchair and assisted with a specific activity every two hours.

B.

On a specific date and time, Inspector #627 observed resident #004 in the dining room. The resident was sitting in a wheelchair with a specific restraint in place. Resident #004 was observed being brought to the TV room, where they had remained for a period of two hours and 40 minutes, when the Inspector exited the unit. The resident had not been repositioned or provided with continence care for three hours and 20 minutes.

At a later date, Inspector #627 observed resident #004 in the dining room for a meal service. The resident was brought to the TV room after the meal service, where they remained until the following meal service. The resident had not been repositioned or provided with continence care when the Inspector exited the unit, after more than five hours.

On a specific date, Inspector observed resident #004 brought to the dining room for a meal service, at a specific time. After the meal service, resident #004 was brought to the TV room where they remained until Inspector #627 left the unit. Resident #004 remained restrained without repositioning or continence care for more than two hours and 35 minutes.

On a following day, Inspector #627 observed resident #004 in the dining room for a meal service, with their restraint in place. Resident #004 was observed being assisted to the TV room where they remained until they were assisted to the dining room for the following meal service. The resident was not repositioned or provided with continence care for four hours.

At a later date, Inspector #627 observed resident #004 being assisted to the TV room after the meal service, where they remained until the following meal service. After the second meal service, resident #004 was observed being assisted back

to the TV room. Inspector #627 approached the RPN and requested that the resident be provided with continence care and repositioned before the end of the shift. Resident #004 was brought to their room and provided care. Resident #004 had not been repositioned for over three hours and 32 minutes.

Inspector #627 reviewed the resident's care plan in effect at the time of the inspection and noted for the focus of safety that the resident was to have a specific restraint in place to prevent a specific ADL from occurring; the resident was to be checked and repositioned every two hours and provided with a specific intervention every two hours.

Inspector #627 interviewed PSW #110 who stated that when a resident was restrained, the restraint was to be removed every two hours, and the resident repositioned and provided with specific interventions; however, this was not happening as there was no time. They further stated that usually, two staff members were completing baths which left only one staff member on the floor to care for all the other residents.

Inspector #627 interviewed PSW #104 who stated that PSWs had usually not completed morning care on all residents until 1000 hours, when the last residents were provided breakfast. They stated that at 1000 hours, the hydration pass was to be completed by a PSW and the other two PSWs completed baths until the staffs' lunch breaks started at 1030 hours, until 1200 hours. Lunch was then provided and residents were toileted and returned to bed if there was time.

Inspector #627 interviewed RPN #107 who stated that a specific unit had all the residents with responsive behaviours and there was no extra staff to help care for them. RPN #107 further stated that if a resident fell frequently, they had a table top applied, as most of the time, the staff were in the resident's room and could not watch the residents. RPN #107 stated that the expectation when a resident was restrained, was that the restraint be removed and the resident repositioned and toileted every two hours. RPN #107 further stated that they told the staff to do the tasks; however, there was no time and there was only so much they (the RPN) could do.

Inspector #627 interviewed RN #119 who stated that the expectation for a resident who was restrained, was to have the restraint removed and the resident repositioned every two hours. RN #119 stated that the "staff could not do it, they tried their best but it couldn't be done"; after breakfast, the hydration pass was

completed and baths had to be started. RN #119 stated that there was no time to reposition the residents. RN #119 stated that they were grateful to the housekeeping staff as they served the residents' breakfast as no one made it to the dining room before 0930 hours. According to the staffing plan, it was not possible to meet all the residents' care needs. We have had extra staff for bathing and during outbreaks." They further stated "we try to give the care, but I will not lie, I do not have enough staff. I've argued with management, but they said that this was the right number of staff for the floor".

Inspector #627 interviewed the DOC who stated that the staffing plan for the specific unit included one RPN, three PSWs and a float PSW, however, there was never enough staff to meet the resident care needs to the level they were entitled to get. The DOC stated that it was their expectation that the RPN and RN would be made aware if care could not be provided as per residents' assessed needs so a solution could be found to address the problem and see what works; they could engage the families or move staff from the other floors. They stated that they were not made aware that residents with restraints were not repositioned every two hours.

C.

On a specific date, Inspector #627 observed a meal service on the second floor unit and noted that resident #018, #019, #020, #021and #022 were restrained. The residents were assisted to the TV room, after the meal service, where they remained until the following meal service, when they were returned to the dining room. The residents were not provided with continence care, repositioned or released from their restraint.

After more than 3.45 hours in their chair, the Inspector observed staff return resident #021 to their room, where they were released from their restraint, transferred to bed and provided with continence care.
After more than 3.45 hours, the Inspector observed resident #022 being released from their restraint, transferred to bed and provided with continence care.
After more than 3.55 hours, the Inspector observed resident #018 released from their restraint, transferred to bed and provided with continence care.
Resident #020 was returned to the TV room where they remained for more than four hours, when the Inspector left the unit.

On a specific date, Inspector #744 observed a meal service on a different unit and

observed the following:

- Resident #021 was assisted from the dining room to the TV room, where they remained, restrained until they were assisted to the dining room for the following meal service, two hours and 30 minutes later. The resident was observed displaying signs of agitation.
- Resident #020 was observed being assisted from the dining room, after a meal service where they remained for two hours and 15 minutes, when they were assisted to the dining room for the following meal service
- Resident #022 was observed being transferred from the dining room to the TV room after a meal service. The resident was observed asking the staff member to go to their room; another staff member suggested that they remain in the TV room to be observed. Approximately 55 minutes later, staff were observed tilting the resident's chair by approximately 30 degrees. Two hours and 15 minutes later, the resident was wheeled to the dining room for the lunch meal service.
- Resident #019 was observed being transferred from the dining room to the TV room after a meal service. Two hours later, the resident was assisted to the dining room from the TV room for the following meal service.

During the period of observation, for a period of three and a half hours, Inspector #744 had not observed any of the residents removed from their restraint and repositioned.

Inspector #627 interviewed PSW #142 who stated that the aforementioned residents had been up from 0615 to 0830 hours. PSW #142 stated that when a resident had a restraint or a personal assistance service device (PASD) that restricted movement, the resident was to have the restraint or PASD removed, and the resident was to be repositioned every two hours. PSW #142 stated that this was done when there was extra staff on the floor, but usually, in the morning, the residents were not repositioned or provided with continence care unless staff noticed a resident "grabbing themselves", or when staff were in the TV room and "we got a bad whiff", then the resident was toileted. PSW #142 further stated that there was no time to remove the restraints, unless the residents were returned to bed; this was the only time that the restraints would have been removed.

Inspector #627 interviewed PSW #113 who stated that they "had never heard" that residents had to be removed from their restraints and repositioned every two hours, except for one specific resident. They stated that on the different floor, staff only tilted the wheelchairs; the restraints were not removed. PSW #113 further

stated that there was a lot of things they had not agreed with; however, there was never enough time to complete all the care.

Inspector #627 interviewed RN #145 who stated that staff were to remove the restraints and reposition residents every two hours. They further stated that the staff received yearly training, and knew this.

Inspector #627 interviewed the DOC who stated that it was the expectation that all residents who were restrained, were to have their restraint removed, and were to be repositioned every two hours. The DOC further stated that they had not felt that the lack of repositioning and the lack of removal of restraints was not due to staffing, as the different unit was adequately staffed, the staff had received education on how to care for residents who were restrained, and had to fill documentation which indicated that the care had been provided. [s. 110. (2) 4.]

***Additional Required Actions:***

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

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

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (3) The staffing plan must,**
**(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).**
**(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).**
**(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).**
**(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).**
**(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that their staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

A.

Ontario Regulation (O.Reg) 79/10 of the Long Term Care Home Act, section (s.) 110 (2) (4) indicates that 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:
4. That the resident is released from the physical device and repositioned at least once every two hours.

A complaint was submitted to the Director in regards to restraints. Please see WN #2 and #3 for details.

Inspector #627 reviewed the home's policy titled "Minimizing Restraining of Residents and the Use of Personal Assistance Service Devices (PASDs)" last

revised May 12, 2017, which indicated that the Long Term Care Homes Act (LTCHA) requirements for a resident who was restrained was to have their restraint removed and the resident repositioned every two hours.

Inspector #627 reviewed the home's policy titled "Staffing Plan and Nursing Staff Shortage Plan", last revised March 3, 2018, which indicated that the goal of the home and its Board of Management was to ensure adequate quality care by continually assessing, monitoring and re-assigning staffing level on a daily basis. Management, encouraged, supported and promoted healthy staffing and workload practices. Additionally, the staffing plan indicated that a full complement of PSWs included:
14 PSWs for eight hours for day shift;
13 PSWs for eight hours per evening shift; and,
4 PSWs for eight hours on night shift.
The staffing plan had not indicated how many PSWs were assigned on each floor.

B.

O.Reg 79/10 of the Long Term Care Home Act, s. 71 (4) indicates that the license must ensure that the planned menu items are offered and available at each meal and snack.

Inspector #627 toured a specific unit at 0930 hours, and noted that most of the wheelchair dependent residents were not in the dining room. When the Inspector questioned a staff member about this, PSW #104 replied that morning care was still being provided and that the residents would be brought to the dining room soon, by the PSWs and housekeeping staff. Please see WN #6 for further details.

Inspector #627 interviewed RN #119 who stated that the expectation for residents who were restrained was to have the restraint removed and the resident reposition every two hours. RN #119 stated that the "staff could not do it, they tried their best but it couldn't be done; after breakfast the hydration pass was completed and baths had to be started". There was no time to reposition the residents. RN #119 stated that they were grateful to the housekeeping staff as they served the residents breakfast as no one made it to the dining room before 0930 hours. RN #119 explained that if the residents arrived after the breakfast lunch service had ended, they were provided with a breakfast of cereal, yogurt

and bananas. RN #119 stated that according to staffing levels, it was not possible to meet all the residents' care needs; however, there was extra staff for bathing and during outbreaks." They further stated "we try to give the care, but I will not lie, I do not have enough staff."

Inspector #627 interviewed the DOC who stated that the staffing plan for the specific unit included one RPN, three PSWs and a float PSW; however, there was never enough staff to meet the resident care needs to the level they were entitled to get. The DOC stated that it was their expectation that the RPN and RN would be made aware if care could not be provided as per residents' assessed needs so a solution could be found to address the problem and see what works; they could engage the families or move staff from the other floors. They stated that they were not made aware that residents with restraints were not repositioned every two hours.

During the periods of observation on the specific unit, a full complement of staff had been present; however, the residents' care needs had remained unmet. [s. 31. (3) (a)]

***Additional Required Actions:***

**CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A1)**
**The following order(s) have been amended: CO# 004**

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

A complaint was submitted to the Director regarding cleanliness in the home.

Inspector #627 interviewed the complainant who stated that they found the home to be "very dirty with a foul smell". As well, during the inspection, a family member approached the Inspector and asked them to "do something about the dirty dining room tables".

Inspector #627 and #744 completed a tour of the dining rooms of the home and noted the following:

- A specific dining hall- all of the 14 tables had grease and gum deposits on the underside of the table;
- A different dining hall- out of the 12 tables, eight tables had grease stains, dried food and gum deposits on the underside of the table;
- Another dining hall- out of 12 tables, 10 tables had grease, dried food and gum deposits on the underside of the table; and,
- The last dining hall – out of 25 tables, 12 had grease and gum deposits under the table.

Inspector #627 reviewed the home's policy titled " House Keeping and Laundry Department Policies and Procedures – Complete Dining Room Cleaning", #H-07, dated April 2009, which indicated to maintain the dining room in a clean and sanitary manner and to clean chairs and tables with germicidal detergent. There was no frequency indicated as to when the tables, (underside, legs) should be

cleaned.

Inspector #627 interviewed Dietary Aide (DA) #138 who stated that housekeeping staff were responsible for cleaning the underside of the tables; the DAs only cleaned the top of the tables after the meal services.

Inspector #627 interviewed Housekeeping staff (HK) #108 who stated that the last time they had cleaned the underside of the tables was 11 months ago. HK #108 stated that when the tables "got too bad", they would clean them instead of cleaning the residents' wheelchairs, as there was no time allotment to clean the tables thoroughly, although they had used their "big mop" to wash the table legs and remove the "big chunks" off them. They further stated that for five out of seven days, there was only one housekeeper per floor and the resident's rooms and wheelchairs were the priority. The two days when there were two housekeepers on the floor were used to catch up on chores that they had not had time to complete. They further stated that their duties included feeding the residents which took up to two hours per day and collecting the laundry which took 30 to 35 minutes per day. HK #108 stated that there was not enough time to clean the tables thoroughly.

Inspector #627 interviewed the Dietary Manager who stated that table tops were cleaned regularly but not the bottom of the tables. They stated that they checked and assigned someone to clean the bottom of the tables as required and that they would be assigning someone today in preparation for Christmas.

Inspector #627 interviewed the Environmental Service Manager (ESM), who was in charge of the housekeeping, maintenance and laundry services. The ESM stated that the visible areas of the tables were cleaned daily and that they had assumed that the bottom of the table would be cleaned. The ESM stated that they would add it to the housekeeping schedule. [s. 15. (2) (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 the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

Inspector #627 toured a specific unit at 0930 hours, and noted that the most of the wheelchair dependent residents were not in the dining room. When the Inspector questioned a staff member about this, PSW #104 replied that morning care was still being provided and that the residents would be brought to the dining room soon, by the PSW and housekeeping staff.

Inspector #627 interviewed DA #105 who stated that they usually arrived at 0845 hours for the breakfast meal service and that usually there was only one independent resident in the dining room. The DA stated that when they left at 1000 hours, there was usually three to four residents who had not been brought to the dining room yet. The DA stated that they left food aside such as cereals, bread, cheese and yogurt for the residents which PSWs could prepare; however the residents who arrived after 1000 hours, were not provided with the planned breakfast items.

Inspector #627 interviewed Housekeeping staff (HK) #108 who stated that they arrived to assist with the breakfast meal at 0900 hours. HK #108 stated that they brought residents from their room to the dining room, set the place settings and put clothes protector on the residents. They further stated that not all residents were in the dining room for breakfast by 1000 hours. HK #108 stated that the DA

had to leave by 1000 hours; therefore, the residents who were brought for breakfast after 1000 hours were provided with toast, cereal, cheese and yogurt as the warm food was put away.

Inspector #627 interviewed PSW #104 who stated that the PSWs usually had not had the time to assist with the breakfast meal as they were providing morning care to the residents. They further stated that "on a good day", a PSW assigned to a specific area "may make it" to the dining room by 0930 hours as that work assignment had more independent residents. The two other PSWs arrived in the dining room by 1000 hours, when the DA left. PSW #104 stated that today, they had not had time to provide morning care to residents #008 and #009. PSW #104 stated that the pureed meals were left behind, there were no eggs left and when the residents came in late, they were provided with toast and cereal; they had no choices and not all residents were provided with full breakfasts.

Inspector #627 interviewed RPN #107 who stated that in the morning, the housekeeping and maintenance staff assisted the residents with their breakfast. They stated that today, all of the residents had been brought to the dining room by 1000 hours as the three staff members working were experienced and they "don't fool around". RPN #107 further stated that when residents were brought in the dining room after 1000 hours, they were provided with cereal, yogurt and bananas. If they didn't want those choices, they were provided with an Ensure. The RPN stated that plate service in the room or in the dining room after 1000 hours was not provided as the staff didn't have time.

On a specified date, Inspector #627 entered a specific unit, and noted that the residents were being assisted out of the unit after breakfast. PSW #110 approached the Inspector and stated that today, there had been four PSWs assigned to the unit for a few hours in the morning and this had permitted the staff to complete all resident care, and allowed the staff to have the residents in the dining room in a timely manner.

Inspector #627 interviewed RN #119 who stated that they were grateful to the housekeeping staff as they served the residents breakfast as no one made it to the dining room before 0930 hours. According to the number of staff (PSW) allocated to the specific unit, it was not possible to meet all the residents' care needs. [s. 71. (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 the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home had a dining and snack service that included the following elements: proper techniques to assist residents' with eating, including safe positioning of residents who required assistance.

During a meal observation on a different unit, Inspector #744 observed resident #018 being assisted with their lunch meal service. Resident #018 was observed to be tilted (not sitting at a 90 degree angle) during the meal service.

Inspector #627 reviewed resident #018's care plan in effect at the time of the inspection and noted for the focus of ADL assistance that the resident was to be sitting upright at a 90 degree position.

Inspector #627 reviewed a external agency report, completed by a Speech

Language Pathologist (SLP), which indicated that resident #018 was to be assisted with meals while sitting in an "upright position".

Inspector #627 interviewed PSW #142 who stated that they could not place resident #018 at a 90 degree position due to limitations. PSW #142 stated that they were unaware of the proper tilt at which resident #018 was to be placed during the meal service.

Inspector #627 interviewed RPN #127 who stated that resident #018 was tilted for meals due to limitations. They further stated that the RN would be made aware of any swallowing difficulty and a referral would be sent by the RN for any assessments. RPN #127 stated that they had always seen the resident reclined for all meals.

Inspector #627 interviewed the RD who stated that sitting a resident at 90 degrees was the norm when assisting a resident with a meal and that any variation would be decided by an SPL. The RD stated that resident #018 had limitations and that it was a question of "did we try to get something into them today, it seemed to work well, but may not be the magic for tomorrow" and that "it may be a risk of aspiration". They further stated that they could not tell the Inspector how it was decided to tilt resident #018 during a meal. When the Inspector informed the RD that the resident was observed tilted at a certain angle, the RD replied "it could be that people had not understood about silent aspirations". They stated that a change of position to assist the resident with meals would not have been discussed with them, it would have been discussed with the care plan team. They further stated that they could ask the Physician for an SLP assessment as none had been completed for a number of years. During a separate interview, the RD stated that the home had no policies in regards to safe positioning during meals; however, staff were taught during orientation that residents should be assisted with their meal while sitting at a 90 degree angle.

Inspector #627 interviewed RN #145 on two separate occasions. RN #145 provided the Inspector with an email from the DOC which stated that there had been no recent SLP assessments as no one had reported any problems for resident #018 in regards to eating. RN #145 informed the Inspector that there would be a referral submitted for an SLP in regards to resident #018's positioning during meals and choking risk. [s. 73. (1) 10.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's SDM, if any, and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's care plan.

Inspector #627 interviewed resident #006's enacted SDM who stated that the resident's medications had been changed without their knowledge. The medications had been reinstated four months later. Resident #006's SDM stated that after the medication changes, they noticed that resident #006 was deteriorating. Resident #006's SDM had asked the home if there had been any changes to resident #006's medications and they were told that there had been no changes. Resident #006's SDM stated that they only became aware of the medication changes when they received a call from an outside agency, to schedule an appointment to follow up on resident #006's medication changes. The resident's SDM stated that they had multiple conversations with the home about the medication changes, and that the Physician had reinstated resident #006's medications.

Inspector #627 reviewed resident #006's care plan in effect at the time of the medication changes and noted for the focus of ADL, that family were to participate in the care plan development.

Inspector #627 reviewed a report from an outside agency which listed the recommendations for medication changes, from the Physician of the outside agency.

Inspector #627 reviewed the home's Physician's orders, for resident #006, which followed the recommendations from the outside agency.

Inspector #627 reviewed a progress note in resident #006's electronic chart, which indicated that resident #006 was seen by the specified outside agency's Physician who had suggested the medication changes.

Inspector #627 interviewed RN #119 who stated that usually, the specific outside agency's Physician called the resident's SDM themselves; however, they had a Nurse Practitioner (NP) with them, who was to call the family, but didn't.

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints**

**Specifically failed to comply with the following:**

**s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home were submitted to the Director.

A complaint was submitted to the Director, by resident #002's family member, in regards to concerns of symptoms not being monitored during an outbreak in the home.

Inspector #627 interviewed resident's #002's family member who stated that they had brought forth a written complaint to the home in regards of symptoms not being monitored during a respiratory outbreak at the home. The complainant provided an example of a time when a volunteer had not worn gloves or personal protective equipment (PPE) during an activity.

Inspector #627 reviewed the home's policy titled "Personnel Policies and Procedures-Reporting and Complaints", #P.P.P.01-120, dated July, 2018, which indicated that if the home received a written complaint concerning the care of a resident or the operation of the home, they were to immediately forward it to the Director at the Ministry of Health and Long-Term Care.

Inspector #627 interviewed the infection prevention and control (IPAC) lead who stated that they had been forwarded the written complaint by the Administrator. The IPAC lead indicated that they had responded to the complainant with explanations of how resident's symptoms were monitored during an outbreak. The IPAC lead further stated that they had not reported the complaint to the Director. This would have been completed by the Administrator.

Inspector #627 interviewed the Administrator who stated that they had not submitted the complaint to the Director as resident #002's family member had stated in their letter and in person that they had not wanted the complaint submitted "to the authorities". The Administrator stated that for this reason, the complaint was dealt with as a verbal complaint and that during the follow up with the complainant, they had stated that they were satisfied with the outcome. [s. 22. (1)]

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Director alleging that the home had failed to administer a specific medication, for resident #002, on four consecutive days.

Inspector #627 interviewed resident #002's family member who stated that resident #002 had called them and made them aware that they had not received a specific medication for a period of four days.

Inspector #627 reviewed a Physician's order indicating that resident #002 was to receive a specific medication four times a day.

Inspector #627 reviewed the electronic administration record in Catalyst for resident #002 for a period of four months and noted that on a specific date, the resident had not received their medication and on the following day, they had missed two doses of the specific medication. During the same review, Inspector #627 noted a scheduled event whereby, the staff member was to re-order the medication monthly. Initials indicated that the specific medication had been reordered.

Inspector #627 reviewed the home's policy titled "Medication System- General Information", #G-015, dated August 2007, which indicated that nursing staff were to reorder three to four days prior to the expiry of the medication.

Inspector #627 interviewed the Pharmacy Assistant who indicated that they had not received a request to refill resident #002's specific medication on the above stated date. The request had been submitted by the home 13 days later, and delivered on the following day. They further stated that the previous request had been submitted the prior month.

Inspector #627 interviewed RPN #117 who stated that it was the expectation that resident #002's specific medication be re-ordered monthly when the scheduled event became due. RPN #117 further stated that it was also the expectation that every nurse would monitor the amount of medication left, and would order the medication at an earlier time after notifying the family to ensure that the resident received their medication as prescribed. RPN #117 reviewed the "pharmacy request – processed" records in Catalyst and verified that the resident's specific medication had not been reordered when it should have been; it was reordered 13 days later.

Inspector #627 interviewed the DOC who stated that resident #002's family had complained that the home was ordering the resident's specific medication too frequently; therefore, a scheduled event was created to ensure that the resident's medication was ordered at the same time each month. The DOC acknowledged that the medication had not be reordered on time, in error.[s. 131. (2)]

**Issued on this 11st day of January, 2019 (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

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Amended Public Copy/Copie modifiée du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by SYLVIE BYRNES (627) - (A1) |
| **Inspection No. / No de l'inspection :** | 2018_752627_0023 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 027786-17, 008628-18, 016380-18, 019295-18, 025765-18, 026967-18 (A1) |
| **Type of Inspection / Genre d'inspection :** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Jan 11, 2019(A1) |
| **Licensee / Titulaire de permis :** | Board of Management for the District of Nipissing West<br>100 Michaud Street, STURGEON FALLS, ON, P2B-2Z4 |
| **LTC Home / Foyer de SLD :** | Au Chateau<br>100 Michaud Street, STURGEON FALLS, ON, P2B-2Z4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Jacques Dupuis |

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

To Board of Management for the District of Nipissing West, 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 :**

LTCHA, 2007 S.O. 2007, c.8, s. 10. (2) Without restricting the generality of subsection (1), the program shall include services for residents with cognitive impairments, and residents who are unable to leave their rooms. 2007, c. 8, s. 10 (2).

**Order / Ordre :**

The licensee shall be compliant with s. 10 (2) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee shall:

A) Ensure that the recreation and social activities program includes a range of indoor and outdoor recreation, leisure and outings that are of the frequency and type to benefit all residents of the home and reflect their interests;

B) Provide supplies and appropriate equipment for the programs;

C) Communicate to all residents and families a schedule of recreation and social activities that are offered during days, evening and weekends for all the units in the home. If the recreation and social activities for the day cannot be offered to residents who are unable to leave their home unit, other activities shall be developed for those residents and a schedule of the alternative activities shall be developed, documented and communicated to the residents and families;

D) Develop and implement small group programs and individualized activities for residents who are not interested or are not able to participate in large groups, residents who are unable to leave their home unit and for residents exhibiting responsive behaviours;

E) Work in collaboration with the Family and Resident Councils to ensure that the Recreation program benefits all residents, including residents who are not able to leave their home unit and residents who exhibit responsive behaviours;

F) Review all the activation care plans of all residents who are unable to leave their home unit independently, due to health, responsive behaviours or preference, to ensure that the activity interventions identified are achievable and implemented;

G) Assistance and support shall be provided to permit residents to participate in activities that may be of interest to them if they are not able to do so independently;

H) All changes and improvements to the Recreation program shall be documented and provided to the Inspector upon request.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that the recreational and social activities program included services for residents with cognitive impairments and residents who were unable to leave their room.

A complaint was submitted to the Director, by resident's #003's family member, alleging that the home had no recreational activities for residents who were cognitively impaired and resided on a specific unit.

Inspector #627 conducted two separate interviews with resident #003's family member, in which resident #003's family member became very emotional. They stated that they found the way that resident #003 was treated, to be cruel. They stated that resident #003 was restrained daily for an extended period of time. They further stated that many restrained residents sat all day long and were not provided with any form of meaningful social activities. Resident #003's family member stated that the residents were bored as they sat, restrained, with nothing to do.

Inspector #627 reviewed the activity calendar posted in the home at the time of the inspection. On the first day of the inspection, the activities listed for the home were

"Resident Council meeting and Bingo". The following day, the listed activities were "Dietary Meeting, Union Cultural and Music/Ghost Rider". The Inspector had not observed any of the listed activities to have occurred on the specific unit. On a specified date, Inspector #627 observed Physiotherapy Assistant (PTA) #112 enter the specific unit and provide the six residents in the TV room, close to the nursing station, with plastic hockey sticks. Five of the six residents were observed playing "hockey" for a period of 11 minutes. Resident #004 was provided with a hockey stick, however they were unable to take part in the activity. The Inspector noted that there was no attempt to gather any other residents to take part in the activity.

Inspector #627 reviewed the home's policy titled "Adjuvant Policies and Procedures, Small Group Activities", #01-006, dated March 2017, which indicated that "small group programs and individualized activities shall be provided for those residents who are not interested or are not able to participate in larger groups. Individual activities shall be organized based on residents' wishes and capabilities".

Inspector #627 reviewed resident #003's care plan in effect at the time of the inspection which indicated for the focus of activation, that resident #003 was to attend/participate in activities of choice, a specific number of times weekly, and to provide a program of activities that was of interest and empowered resident #003 by encouraging/allowing choice, self-expression and responsibility, adapted to their capabilities. Staff were to assist/escort resident #003 to activities of choice that reflected prior interests and desired activity level. For the focus of behaviour/mood, resident #003's care plan indicated to distract the resident with a range of activities.

Inspector #627 interviewed Personal Support Worker (PSW) #110 who stated that there was perhaps one activity per month on the specific unit, and that most of the time, the activity was manicures. They stated that it was always the same three or four ladies that took part in the manicure activity because "they were quiet and had no responsive behaviours". They further stated that there were no activities for the residents with dementia or those who exhibited responsive behaviours. PSW #110 further stated that none of the activities in resident #003's care plan were offered as PSW staff had not had the time to complete activities with the residents, and that the Recreation department staff were rarely on the unit.

Inspector #627 was approached by PSW #143 during the inspection. PSW #143 shared with the Inspector that there no longer were activities for the residents. They

stated that the Recreational department was always short staffed, and the Manager continuously refused to buy supplies stating that there was no money for supplies; for example, for Halloween, oranges had been purchased to decorate instead of pumpkins as this was cheaper. They further stated that the only activities they had seen were bingo, on Friday and Monday and manicures on Fridays which were provided mostly on another floor. The weekends had no activities. PSW #143 further stated that the Manager of the Recreation department told the Adjuvants (Activity Aides) that there would no longer be one on one activities; they told us "it will never happen". PSW #143 stated that their previous Manager had made the specific unit their priority; now there were no activities on the specific unit.

Inspector #627 interviewed Activity Aide (AA) #115 who stated that the Recreation department "was going through a shuffle". A full complement of staff comprised of four full-time and one part-time employee; however, presently the department had two full-time employees, one of which was working reduced hours, one part-time employee and one casual employee. Additionally, one of the full-time employees was now completing paper work only. AA #115 stated that they had returned to work approximately a few months ago and had been made aware that the "specific unit had been hit hard" and that they were always the last to have activities. AA #115 stated that it was sad as the residents appeared so happy when someone came to the unit and sang. They further stated that most of the activities were geared towards other units, where the residents were more independent, and that the specific unit "got nothing". AA #115 shared with the Inspector that previously, the AAs had taken residents to the Snoozelin room; however, they were told to stop, as the home had not wanted one on one activities. They insisted on group activities.

Inspector #627 interviewed the Resident Services Coordinator (RSC), who was lead for the Recreation department. They stated that there should be five AAs for the Activity program; however, the department only had three AAs for the last five to six months. They acknowledged that the specific unit, identified in the complaint, had not had many activities and that "they had been suffering for a while; however, they just didn't have the bodies". The RSC further stated that they had been told by their former Supervisor that one on one activities were not to occur and that all activities should be group activities. They further acknowledged that there were no activities for residents who exhibited responsive behaviours and advanced dementia. [s. 10. (2)]

The severity of this issue was determined to be a level two, as there was potential for harm. The scope of the issue was a level three, as it was widespread to many residents. The home had a level two compliance history of one or more unrelated non-compliance in the last three years.

(627)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 15, 2019(A1)

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**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

**Order / Ordre :**

The licensee shall be compliant with s. 31 (2) of the LTCHA.

Specifically, the licensee shall:

A) Complete a review and assess all residents who utilize a restraint or a PASD which limits movements. This written assessment shall include but not be limited to:

- The clinical indicators that potentially require physical restraints;
- Include the precipitating factors for considering a restraint including the clinical indicators that necessitates the physical restraint;
- Include any/all alternatives that are trialed or considered and why they were not suitable. Document the time and duration of the trial of all alternatives that were trialed;
- Obtain input from interdisciplinary team members which will include RPNs and HCAs, Behavioural Service Ontario (BSO) and Physiotherapy.
- Include measurable goals such as reduction and elimination of the restraint, reduction of the severity, duration and/ or frequency of use. The goal shall clearly define when the resident's use of restraint, severity, duration and frequency is to be re-assessed;
- Ensure the care plan strategies have adopted the least restrictive restraint for the shortest amount of time necessary.

B) Identify who will be responsible for the reassessments.

C) The above assessments and who participated shall be documented and provided to the Inspector upon request.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that the plan of care included the method of restraining that was reasonable, in light of the resident's physical and mental condition that was the least restrictive method that was effective to address the risk.

A complaint was submitted to the Director regarding concerns with restraining.

A.

Inspector #627 interviewed resident #003's enacted substitute decision maker (SDM) who stated that resident #003 was being restrained, as the resident had demonstrated responsive behaviours. Resident #003's SDM stated that resident #003 became agitated due to certain triggers, which made them react. Resident #003's SDM stated that there were no activities on the unit, and the residents were bored, which caused more responsive behaviours. Resident #003's SDM stated that they were called one day by RN #119, who informing them that resident #003 had to be restrained for the safety of all residents, and that no alternatives were discussed.

Inspector #627 reviewed the home's policy titled "Minimizing Restraining of Residents and the Use of Personal Assistance Service Devices (PASDs)", last revised May 12, 2017, which indicated, to include any/all alternatives that were tried/considered and why they were not suitable. Obtain input from interdisciplinary team members (e.g. RN, RPN, PSW, Physiotherapist, Occupational therapist), to identify alternative treatment options to be tried prior to the use of restraints. Alternative treatment to restraints- a method that imposes less control on the resident than restraining or confining the resident e.g. using a monitoring/safety device on a resident to deal with incidents such as falls, wandering, and aggressiveness were an alternate treatment intervention.

Inspector #627 reviewed a report from an outside agency, regarding resident #003. The report suggested to use restraints as an "absolute last resort".

Inspector #627 reviewed resident #003's care plan in effect at the time of the inspection which identified specific interventions for the focus of physical restraints. For the focus of behaviour, multiple interventions were listed to distract and to provide a sense of self-worth. It was also indicated to continuously try alternative interventions to restraints. For the focus of pain, an intervention listed was to encourage mobility, physical activity as tolerated. For the focus of activities, specific interventions which were to occur at specific times were identified.

Inspector #627 reviewed resident #003's progress notes from a period of five months which identified documentation of 12 instances where resident #003 had demonstrated responsive behaviours towards other residents. The last progress note identified that RN #119 had called resident #003's SDM informing them that resident #003 was to be restrained as the resident was exhibiting responsive

behaviours, which may have been a danger to other residents. Specific interventions for the care of resident #003, while they were restrained, was also mentioned by RN #119.

Inspector #627 interviewed PSW #104 who stated that resident #003 was restrained as the resident exhibited responsive behaviours towards other residents and staff. PSW #104 stated that resident #003 had an intervention in place that had been effective; however, the intervention could not be continued. As well, other interventions had been trialed. PSW #104 stated that RN #119 decided who was going to be restrained.

Inspector #627 interviewed PSW #110 who stated that a specific activity was a trigger for resident #003's responsive behaviours, and since the activity occurred frequently, resident #003 was restrained. PSW #110 stated that the resident had not received the interventions listed for care while restrained due to staff workload. As well, they stated that resident #003 should be taken out of their restraint every two hours and that this had not occurred regularly due to the workloads of staff. PSW #110 also stated that none of the activities listed in the care plan had been trialed as there were no activities on the floor except for the odd manicure day and that staff (PSW) had not had the time to engage the residents in activities. PSW #110 stated that residents in wheelchairs were never taken to activities outside of the unit unless they had a family member to take them, nor was there any trials to reduce the resident's trigger, except for leaving the resident in their room, alone and restrained. PSW #110 stated that restraining resident #003 caused them to become more agitated; PSW #110 further stated that resident #003's responsive behaviours towards others were stopped promptly and that no one had sustained injuries. PSW #104 further stated that the residents with restraints were reassessed by the RN; however, PSWs were not asked for input.

Inspector #627 interviewed RPN #107 who stated that if a resident had a lot of falls, the resident was placed in a wheelchair with an untied table top and if the resident removed the table top, then it was tied in the back. RPN #107 stated that alarms had been trialed; however, since the staff were usually in the rooms providing care, the alarms were not heard. RPN #107 stated that resident #003 was restrained due to responsive behaviours; a specific activity would trigger resident #003, and then, "the behaviours started". RPN #107 stated that the unit no longer had activities regularly, and that residents were not brought to activities outside the unit. They further stated

that activities in the evening would be beneficial as this was when most of the responsive behaviours occurred.

Inspector #627 interviewed Behavioural Services Ontario (BSO) PSW who described their duties as requesting Dementia Observation System (DOS) charting to be completed to try to establish a pattern for a resident's behaviours, which they provided to the RN, who would be the one to follow up on the findings. They stated that part of their role was to make recommendations to keep the resident's hands busy, although they had not worked directly with the residents. The BSO PSW stated that they had been involved with resident #003 mostly to address a different responsive behaviour, and that they had found that specific activities were resident #003's triggers. They further stated that the resident was a "walker" and that this could not be helped and had to be stopped due to the resident's responsive behaviours. The Inspector asked if the recommendations made by the outside agency had been trialed prior to restraining the resident to which the BSO PSW stated, "not by me". They further stated that there had been no activities on the unit for "the longest time"; however, there was music playing at times on the unit.

Inspector #627 interviewed RN #129 who stated that they, and the Resident Assessment Instrument (RAI) Coordinator, had quarterly restraint meetings to discuss what restraints were in place, how many residents were restrained, and to look at the resident's behaviour scores to see if the number of restraints used could be decreased. They stated that resident #003 was restrained due to responsive behaviours as they were a risk to themselves and others. RN #129 further stated that they had not thought that anything else was trialed prior to the restraints, and that they had not attempted to reduce the use of resident #003's restraints.

Inspector #627 interviewed RN #119 who stated that due to resident #003's responsive behaviours, they had no choice but to restrain resident #003. RN #119 stated that they had attempted redirecting, which had been effective; however, staff were not able to watch resident #003 all the time. RN #119 stated that the resident was assessed in the beginning for a lesser restraint; however, nothing else was trialed and they had not been reassessed as they were expected to be transferred soon. RN #119 stated that increased safety check was not trialed, a specific activity was not identified as a trigger, another specific intervention had been trialed; however, another resident interfered with the intervention. RN #119 further stated that the home had not had an alarming system to monitor the resident, and if they

(RN #119) could have trusted resident #003, they would have assessed them for a lesser restraint, and that perhaps now, a specific intervention would be effective and they could trial a removal of the restraint.

Inspector #627 interviewed the Director of Care (DOC) who stated that resident #003 was restrained to address their responsive behaviours towards other residents. They further stated that a specific intervention had been trialed and was effective; however, this could not be sustained. The DOC stated nothing else was trialed aside from the current restraint (no lesser restraint).

B.

Inspector #627 observed resident #004 on a specific unit, with a specific restraint in place.

Inspector #627 reviewed a progress note, which indicated that resident had a certain number of falls, in a two month period. All of the resident's falls involved a specific activity of daily living (ADL). They had specific interventions in place; although, due to their health status, the resident was no longer able to complete the ADL. Resident #004 often fell and frequently, this was because resident #004 attempted to complete the specific ADL.

Inspector #627 reviewed resident #004's care plan in effect prior to the resident being restrained and noted for the focus of ADL, the care plan advised staff that resident #004 required a specific level of assistance while completing the specific ADL.

Inspector #627 reviewed resident #004's care plan for the focus of ADL after the restraint was applied which indicated that the resident required an increased level of assistance for a specific ADL and included interventions that were more restrictive to their mobility.

Inspector #627 reviewed resident #004's minimal data set (MDS) assessment (the last assessment prior to restraints being applied), which indicated that the resident required a specific level of assistance while performing a specific ADL due to responsive behaviours.

Inspector #627 reviewed resident #004's MDS assessment (after the restraint was applied), which indicated that the resident required extensive assistance and was totally dependent on staff for the specific ADL.

Inspector #627 interviewed PSW #104 who stated that they were not sure why resident #004 was restrained as the interventions were probably no longer necessary.

Inspector #627 interviewed RPN #107 who stated that they were not supposed to restrain anyone that could walk, unless there was a reason. RPN #107 further stated that if a resident had a lot of falls or an unsteady gait, the resident was sat in a wheelchair and an untied table top was applied, and if the resident removed the table top, then the table top was tied at the back.

Inspector #627 interviewed RN #119 who stated that resident #004 had a lot of falls while completing a specific ADL. They further stated that the resident had been restrained for "as long as they could remember". The RN stated that the resident had a specific intervention for falls; however, by the time staff responded, the resident had fallen. For this reason, an intervention that prevented the resident from attempting the specific ADL had been implemented. They further stated that the resident had not been assessed for a lesser restraint as seat belts that locked were no longer permitted.

Inspector #627 interviewed RN #129 who stated that resident #004 used to be ambulatory, and by applying a restraint, they were no longer able to complete a specific ADL by themselves, which reduced their risk of falls. RN #129 further stated that the restraint was to prevent the resident from completing a specific ADL and that it had "never clued in" that they may not have needed the restraint.

Inspector #627 interviewed the DOC who stated that resident #004 was restrained as they had "wobbly legs". The DOC further stated that nothing else had been trialed and that there was a decision tree to assist with the decision to restrain someone; however, it had not been utilized.

C.

During the inspection, Inspector #627 observed resident #005 with a specific restraint

in place.

Inspector #627 reviewed resident #005's care plan in effect at the time of the inspection and noted for the focus of restraint that the resident was to have a specific intervention in place.

Inspector #627 reviewed resident #005's progress notes which indicated a specific number of instances whereby resident #004 had ambulating independently after removing their restraint. The resident had been unharmed.

Inspector #627 interviewed PSW #104 who stated that resident #005 was restrained; however, they no longer needed the restraint as they completed a specific ADL independently.

Inspector #627 interviewed RPN #107 who stated that resident #005 was restrained due to falls. They further stated that resident #005 previously had a specific intervention in place; however, it had failed as an intervention as staff had been busy caring for other residents. RPN #107 stated that resident #005 completed a specific ADL independently, although they were not supposed to, and that perhaps they should have been reassessed as they may no longer needed to be restrained.

Inspector #627 interviewed RN #119 who stated that resident #005 had a restraint as they fell all the time. They further stated that a lesser restraint had not been considered.

Inspector #627 interviewed the DOC who stated that resident #005 had a specific restraint for their safety. They further stated that there was no documentation to indicate that the resident was reassessed for the use of a restraint and that usually, residents were reassessed to see if the restraint could be removed completely and not to explore for a lesser restraint. [s. 31. (2) 3.]

The severity of this issue was determined to be a level two, as there was potential for harm. The scope of the issue was a level three, as it was widespread to many residents. The home had a level two compliance history of one or more unrelated non-compliance in the last three years. (627)

Mar 12, 2019(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

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

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**Order # / Ordre no :** 003

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

**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 :**

(A1)
The licensee shall be compliant with Ontario Regulation (O.Reg.) 79/10, s. 110 (2), of the LTCHA.

The license is required to prepare, submit and implement a plan for achieving compliance under O. Reg. 79/10, s. 110 (2) of the LTCHA. The plan shall include but not be limited to:

1) Ensuring that residents who are restrained with a physical device or a PASD that limits movement are released from the physical device and repositioned at least every two hours.

2) Develop, implement, and maintain records for an auditing process to ensure that residents who are restrained with a physical device or a PASD that limits movement are released from the physical device and repositioned at least every two hours.

3) The plan shall identify who will be responsible for the audits and the frequency of the audits.

Please submit the written plan, quoting inspection #2018_752627_0024 and Sylvie Byrnes by email to SudburySAO.moh@ontario.ca, by February 5, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that when a resident was restrained by a physical device under section 31 or section 36 of the Act, the resident was released from the physical device and repositioned at least once every two hours.

A complaint was submitted to the Director regarding concerns with restraining. Please see WN #2, item A, for details.

Inspector #627 interviewed resident #003's enacted SDM who stated that resident #003 was being restrained to keep them "out of trouble"; however, they had been told by staff members that resident was not removed from their restraint every two hours

regularly, due to staffing and workload.

Inspector #627 conducted a tour of the specific unit and noted that many residents (13) were restrained with a table top attached to their wheelchair.

Inspector #627 reviewed the home's policy titled "Minimizing Restraining of Residents and the Use of Personal Assistance Service Devices (PASDs)" last revised May 12, 2017, which indicated that the Long Term Care Homes Act (LTCHA) requirements for a resident who was restrained was to have their restraint removed and the resident repositioned every two hours.

A.

On a specific date and time, during a meal service, resident #003 was observed sitting at a two person table. The resident was restrained. The resident was brought to the TV room after the meal, where they remained for a period of almost three hours. The resident was observed demonstrating a specific behaviour while restrained, until they were provided with assistance with a specific ADL.

At a later date, Inspector #627 observed resident #003 being brought to the dining room, with the restraints in place. The Inspector observed resident #003 returned to their room at a specific time, where they remained until the next meal service, when they were brought to the dining room. The resident was not repositioned or provided with continence care prior to the meal service. The resident was returned to their room, where they remained. The resident had not been repositioned or provided with continence care for a period of over four hours, when the resident was observed completing a specific ADL with a family member.

Inspector #627 reviewed resident #003's care plan in effect at the time of the inspection and noted for the focus of "physical restraint" that the resident was to have two specific restraints in place. The interventions included repositioning every two hours and the application of a restraint at all times except at meals due to having more staff in the dining room to supervise. The care plan advised staff that the resident was to be removed from their wheelchair and assisted with a specific activity every two hours.

B.

On a specific date and time, Inspector #627 observed resident #004 in the dining room. The resident was sitting in a wheelchair with a specific restraint in place. Resident #004 was observed being brought to the TV room, where they had remained for a period of two hours and 40 minutes, when the Inspector exited the unit. The resident had not been repositioned or provided with continence care for three hours and 20 minutes.

At a later date, Inspector #627 observed resident #004 in the dining room for a meal service. The resident was brought to the TV room after the meal service, where they remained until the following meal service. The resident had not been repositioned or provided with continence care when the Inspector exited the unit, after more than five hours.

On a specific date, Inspector observed resident #004 brought to the dining room for a meal service, at a specific time. After the meal service, resident #004 was brought to the TV room where they remained until Inspector #627 left the unit. Resident #004 remained restrained without repositioning or continence care for more than two hours and 35 minutes.

On a following day, Inspector #627 observed resident #004 in the dining room for a meal service, with their restraint in place. Resident #004 was observed being assisted to the TV room where they remained until they were assisted to the dining room for the following meal service. The resident was not repositioned or provided with continence care for four hours.

At a later date, Inspector #627 observed resident #004 being assisted to the TV room after the meal service, where they remained until the following meal service. After the second meal service, resident #004 was observed being assisted back to the TV room. Inspector #627 approached the RPN and requested that the resident be provided with continence care and repositioned before the end of the shift. Resident #004 was brought to their room and provided care. Resident #004 had not been repositioned for over three hours and 32 minutes.

Inspector #627 reviewed the resident's care plan in effect at the time of the inspection and noted for the focus of safety that the resident was to have a specific restraint in place to prevent a specific ADL from occurring; the resident was to be

checked and repositioned every two hours and provided with a specific intervention every two hours.

Inspector #627 interviewed PSW #110 who stated that when a resident was restrained, the restraint was to be removed every two hours, and the resident repositioned and provided with specific interventions; however, this was not happening as there was no time. They further stated that usually, two staff members were completing baths which left only one staff member on the floor to care for all the other residents.

Inspector #627 interviewed PSW #104 who stated that PSWs had usually not completed morning care on all residents until 1000 hours, when the last residents were provided breakfast. They stated that at 1000 hours, the hydration pass was to be completed by a PSW and the other two PSWs completed baths until the staffs' lunch breaks started at 1030 hours, until 1200 hours. Lunch was then provided and residents were toileted and returned to bed if there was time.

Inspector #627 interviewed RPN #107 who stated that a specific unit had all the residents with responsive behaviours and there was no extra staff to help care for them. RPN #107 further stated that if a resident fell frequently, they had a table top applied, as most of the time, the staff were in the resident's room and could not watch the residents. RPN #107 stated that the expectation when a resident was restrained, was that the restraint be removed and the resident repositioned and toileted every two hours. RPN #107 further stated that they told the staff to do the tasks; however, there was no time and there was only so much they (the RPN) could do.

Inspector #627 interviewed RN #119 who stated that the expectation for a resident who was restrained, was to have the restraint removed and the resident repositioned every two hours. RN #119 stated that the "staff could not do it, they tried their best but it couldn't be done"; after breakfast, the hydration pass was completed and baths had to be started. RN #119 stated that there was no time to reposition the residents. RN #119 stated that they were grateful to the housekeeping staff as they served the residents' breakfast as no one made it to the dining room before 0930 hours. According to the staffing plan, it was not possible to meet all the residents' care needs. We have had extra staff for bathing and during outbreaks." They further stated "we try to give the care, but I will not lie, I do not have enough staff. I've

argued with management, but they said that this was the right number of staff for the floor".

Inspector #627 interviewed the DOC who stated that the staffing plan for the specific unit included one RPN, three PSWs and a float PSW, however, there was never enough staff to meet the resident care needs to the level they were entitled to get. The DOC stated that it was their expectation that the RPN and RN would be made aware if care could not be provided as per residents' assessed needs so a solution could be found to address the problem and see what works; they could engage the families or move staff from the other floors. They stated that they were not made aware that residents with restraints were not repositioned every two hours.

C.

On a specific date, Inspector #627 observed a meal service on the second floor unit and noted that resident #018, #019, #020, #021and #022 were restrained. The residents were assisted to the TV room, after the meal service, where they remained until the following meal service, when they were returned to the dining room. The residents were not provided with continence care, repositioned or released from their restraint.

After more than 3.45 hours in their chair, the Inspector observed staff return resident #021 to their room, where they were released from their restraint, transferred to bed and provided with continence care.
After more than 3.45 hours, the Inspector observed resident #022 being released from their restraint, transferred to bed and provided with continence care.
After more than 3.55 hours, the Inspector observed resident #018 released from their restraint, transferred to bed and provided with continence care.
Resident #020 was returned to the TV room where they remained for more than four hours, when the Inspector left the unit.

On a specific date, Inspector #744 observed a meal service on a different unit and observed the following:

- Resident #021 was assisted from the dining room to the TV room, where they remained, restrained until they were assisted to the dining room for the following meal service, two hours and 30 minutes later. The resident was observed displaying

signs of agitation.
- Resident #020 was observed being assisted from the dining room, after a meal service where they remained for two hours and 15 minutes, when they were assisted to the dining room for the following meal service
- Resident #022 was observed being transferred from the dining room to the TV room after a meal service. The resident was observed asking the staff member to go to their room; another staff member suggested that they remain in the TV room to be observed. Approximately 55 minutes later, staff were observed tilting the resident's chair by approximately 30 degrees. Two hours and 15 minutes later, the resident was wheeled to the dining room for the lunch meal service.
- Resident #019 was observed being transferred from the dining room to the TV room after a meal service. Two hours later, the resident was assisted to the dining room from the TV room for the following meal service.

During the period of observation, for a period of three and a half hours, Inspector #744 had not observed any of the residents removed from their restraint and repositioned.

Inspector #627 interviewed PSW #142 who stated that the aforementioned residents had been up from 0615 to 0830 hours. PSW #142 stated that when a resident had a restraint or a personal assistance service device (PASD) that restricted movement, the resident was to have the restraint or PASD removed, and the resident was to be repositioned every two hours. PSW #142 stated that this was done when there was extra staff on the floor, but usually, in the morning, the residents were not repositioned or provided with continence care unless staff noticed a resident "grabbing themselves", or when staff were in the TV room and "we got a bad whiff", then the resident was toileted. PSW #142 further stated that there was no time to remove the restraints, unless the residents were returned to bed; this was the only time that the restraints would have been removed.

Inspector #627 interviewed PSW #113 who stated that they "had never heard" that residents had to be removed from their restraints and repositioned every two hours, except for one specific resident. They stated that on the different floor, staff only tilted the wheelchairs; the restraints were not removed. PSW #113 further stated that there was a lot of things they had not agreed with; however, there was never enough time to complete all the care.

Inspector #627 interviewed RN #145 who stated that staff were to remove the restraints and reposition residents every two hours. They further stated that the staff received yearly training, and knew this.

Inspector #627 interviewed the DOC who stated that it was the expectation that all residents who were restrained, were to have their restraint removed, and were to be repositioned every two hours. The DOC further stated that they had not felt that the lack of repositioning and the lack of removal of restraints was not due to staffing, as the different unit was adequately staffed, the staff had received education on how to care for residents who were restrained, and had to fill documentation which indicated that the care had been provided. [s. 110. (2) 4.]

The severity of this issue was determined to be a level two, as there was potential for harm. The scope of the issue was a level three, as it was widespread to many residents. The home had a level two compliance history of one or more unrelated non-compliance in the last three years.

(627)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 19, 2019(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

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**Order # / Ordre no :** 004

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

**Order / Ordre :**

The licensee must be compliant with O.Reg. 79/10, s 31 (3) of the LTCHA.

Specifically, the licensee shall ensure that:

A) Management will complete a time analysis study of the specified unit residents' care and safety needs in collaboration with a PSW and an RPN who are regularly assigned to that specific unit unit;

B) Review, revise and implement the staffing plan to ensure that assessed resident care and safety needs on the specified unit are met;

C) Develop, implement, and maintain records for an auditing process to ensure that when working short staffed, or on busier than usual days, all resident care that is missed is followed up with; and,

D) Improve the communication between staff and management to determine gaps in providing resident care, safety issues, and actions taken by providing and recording monthly staff meetings.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that their staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

A.

Ontario Regulation (O.Reg) 79/10 of the Long Term Care Home Act, section (s.) 110 (2) (4) indicates that 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:
4. That the resident is released from the physical device and repositioned at least once every two hours.

A complaint was submitted to the Director in regards to restraints. Please see WN #2 and #3 for details.

Inspector #627 reviewed the home's policy titled "Minimizing Restraining of

Residents and the Use of Personal Assistance Service Devices (PASDs)" last revised May 12, 2017, which indicated that the Long Term Care Homes Act (LTCHA) requirements for a resident who was restrained was to have their restraint removed and the resident repositioned every two hours.

Inspector #627 reviewed the home's policy titled "Staffing Plan and Nursing Staff Shortage Plan", last revised March 3, 2018, which indicated that the goal of the home and its Board of Management was to ensure adequate quality care by continually assessing, monitoring and re-assigning staffing level on a daily basis. Management, encouraged, supported and promoted healthy staffing and workload practices. Additionally, the staffing plan indicated that a full complement of PSWs included:
14 PSWs for eight hours for day shift;
13 PSWs for eight hours per evening shift; and,
4 PSWs for eight hours on night shift.
The staffing plan had not indicated how many PSWs were assigned on each floor.

B.

O.Reg 79/10 of the Long Term Care Home Act, s. 71 (4) indicates that the license must ensure that the planned menu items are offered and available at each meal and snack.

Inspector #627 toured a specific unit at 0930 hours, and noted that most of the wheelchair dependent residents were not in the dining room. When the Inspector questioned a staff member about this, PSW #104 replied that morning care was still being provided and that the residents would be brought to the dining room soon, by the PSWs and housekeeping staff. Please see WN #6 for further details.

Inspector #627 interviewed RN #119 who stated that the expectation for residents who were restrained was to have the restraint removed and the resident reposition every two hours. RN #119 stated that the "staff could not do it, they tried their best but it couldn't be done; after breakfast the hydration pass was completed and baths had to be started". There was no time to reposition the residents. RN #119 stated that they were grateful to the housekeeping staff as they served the residents breakfast as no one made it to the dining room before 0930 hours. RN #119 explained that if the residents arrived after the breakfast lunch service had ended, they were provided with a breakfast of cereal, yogurt and bananas. RN #119 stated

that according to staffing levels, it was not possible to meet all the residents' care needs; however, there was extra staff for bathing and during outbreaks." They further stated "we try to give the care, but I will not lie, I do not have enough staff".

Inspector #627 interviewed the DOC who stated that the staffing plan for the specific unit included one RPN, three PSWs and a float PSW; however, there was never enough staff to meet the resident care needs to the level they were entitled to get. The DOC stated that it was their expectation that the RPN and RN would be made aware if care could not be provided as per residents' assessed needs so a solution could be found to address the problem and see what works; they could engage the families or move staff from the other floors. They stated that they were not made aware that residents with restraints were not repositioned every two hours.

During the periods of observation on the specific unit, a full complement of staff had been present; however, the residents' care needs had remained unmet. [s. 31. (3) (a)]

The severity of this issue was determined to be a level two, as there was potential for harm. The scope of the issue was a level three, as it affected many residents. The home had a level two compliance history of one or more unrelated non-compliance in the last three years.

(627)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 15, 2019(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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

## 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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  11st  day of January, 2019 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :**

Amended by SYLVIE BYRNES (627) - (A1)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

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**Service Area Office / Bureau régional de services :** Sudbury Service Area Office