



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

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

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

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

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

Ottawa Service Area Office  
347 Preston St, 4th Floor  
OTTAWA, ON, L1K-0E1  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa  
347, rue Preston, 4<sup>ième</sup> étage  
OTTAWA, ON, L1K-0E1  
Téléphone: (613) 569-5602  
Télécopieur: (613) 569-9670

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

## **Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 10, 2015	2015_225126_0002	O-001334- 14	Follow up

### **Licensee/Titulaire de permis**

DUNDAS MANOR LIMITED  
533 CLARENCE STREET, P.O. BOX 970, WINCHESTER, ON, K0C-2K0

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

DUNDAS MANOR NURSING HOME  
533 CLARENCE STREET, P.O. BOX 970, WINCHESTER, ON, K0C-2K0

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

LINDA HARKINS (126)

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

**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): January 16 and 21, 2015**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, several registered nursing staff, several personal support workers and several residents.**

**During the course of the inspection, the inspector(s) reviewed the new restraint policy and observed care and services provided to residents.**

**The following Inspection Protocols were used during this inspection:  
Minimizing of Restraining**



Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 31. Restraining by physical devices**

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

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

**Findings/Faits saillants :**



1. The licensee has failed to ensure that a physical device such as a front closure seat belt was not included in the plan of care of Resident # 005.

On January 16, 2015, it was observed that Resident # 005 was sitting in a wheel chair with a front closure seat belt on. Inspector # 126 and Assistant Director of Care asked Resident # 005 what the front closure seat belt was for, Resident #005 was unable to answer and was unable to undo the front closure seat belt. The ADOC indicated that she was not aware that Resident # 005 had a front closure seat belt and was not on the list of the restrained residents.

Resident # 005's health care record was reviewed. No documentation was found related the the physician order and consent was not obtained for the application of the physical device (front closure seat belt).

Discussion held with S# 103 and S# 104, both were unsure of the reason why and when the belt was applied. S# 103 did not ensure Resident # 005 was monitored while restrained in accordance with the requirements provided in the regulations (110.2.6." 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")

During a discussion with with two Personal Support Workers they indicated they did not know why the front closure seat belt was applied to Resident # 005.

Staff were restraining Resident # 005 with a physical device (front closure seat belt) and did not implement the newly revised restraint policy.

It was noted that the home recently implemented and revised the Restraint Policy. Education was provided to nursing staff related to the identification of the restraint and the requirements for all staff as per legislation. Residents identified with physical devices during the implementation of the new policy were noted to have all the required documentation as per policy requirement.



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***Additional Required Actions:***

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

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**Issued on this 10th day of February, 2015**

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



**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*

**Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch**

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

**Public Copy/Copie du public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** LINDA HARKINS (126)

**Inspection No. /**

**No de l'inspection :** 2015\_225126\_0002

**Log No. /**

**Registre no:** O-001334-14

**Type of Inspection /**

**Genre**

Follow up

**d'inspection:**

**Report Date(s) /**

**Date(s) du Rapport :** Feb 10, 2015

**Licensee /**

**Titulaire de permis :**

DUNDAS MANOR LIMITED  
533 CLARENCE STREET, P.O. BOX 970,  
WINCHESTER, ON, K0C-2K0

**LTC Home /**

**Foyer de SLD :**

DUNDAS MANOR NURSING HOME  
533 CLARENCE STREET, P.O. BOX 970,  
WINCHESTER, ON, K0C-2K0

**Name of Administrator /**

**Nom de l'administratrice**

**ou de l'administrateur :**

Norm Slatter

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To DUNDAS MANOR LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:



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

**Order(s) of the Inspector**

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

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

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de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée, L.O. 2007, chap. 8*

**Order # /**

Ordre no : 001

**Order Type /**

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

**Linked to Existing Order /**

Lien vers ordre existant: 2014\_225126\_0029, CO #001;

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall ensure that all residents restrained by a physical device are included in the resident's plan of care only if all of the following are satisfied:

A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

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.

The resident is monitored while restrained, in accordance with the requirements provided for in the regulations; "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."

**Grounds / Motifs :**

1. The licensee has failed to ensure that a physical device such as a front closure seat belt was not included in the plan of care of Resident # 005.

On January 16, 2015, it was observed that Resident # 005 was sitting in a wheel chair with a front closure seat belt on. Inspector # 126 and Assistant Director of Care asked Resident # 005 what the front closure seat belt was for, Resident #005 was unable to answer and was unable to undo the front closure seat belt. The ADOC indicated that she was not aware that Resident # 005 had a front closure seat belt and was not on the list of the restrained residents.

Resident # 005's health care record was reviewed. No documentation was found related the the physician order and consent was not obtained for the application of the physical device (front closure seat belt).

Discussion held with S# 103 and S# 104, both were unsure of the reason why and when the belt was applied. S# 103 did not ensure Resident # 005 was monitored while restrained in accordance with the requirements provided in the regulations (110.2.6." 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")

During a discussion with with two Personal Support Workers they indicated they did not know why the front closure seat belt was applied to Resident # 005.

Staff were restraining Resident # 005 with a physical device (front closure seat belt) and did not implement the newly revised restraint policy.

It was noted that the home recently implemented and revised the Restraint Policy. Education was provided to nursing staff related to the identification of the restraint and the requirements for all staff as per legislation. Residents identified with physical devices during the implementation of the new policy were noted to have all the required documentation as per policy requirement. (126)





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

**Ordre(s) de l'inspecteur**

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

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

Mar 02, 2015



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

**Ministère de la Santé et  
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de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

### **REVIEW/APPEAL INFORMATION**

#### **TAKE NOTICE:**

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

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

The written request for review must include,

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

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

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



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de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée, L.O. 2007, chap. 8*

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar  
151 Bloor Street West  
9th Floor  
Toronto, ON M5S 2T5

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).



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## **RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL**

### **PRENDRE AVIS**

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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



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de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée, L.O. 2007, chap. 8*

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

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

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

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

**Issued on this 10th day of February, 2015**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** LINDA HARKINS

**Service Area Office /**

**Bureau régional de services :** Ottawa Service Area Office