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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 15, 19, 2018	2018_776613_0002	013075-18	Resident Quality Inspection

Licensee/Titulaire de permis

Santé Manitouwadge Health
1 Health Care Crescent MANITOUWADGE ON P0T 2C0

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

Santé Manitouwadge Health
1 Health Care Crescent MANITOUWADGE ON P0T 2C0

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

LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 1 - 4, 2018.

Inspector Debbie Warpala (577) also conducted this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Nursing (DON), Nursing Manager (NM), Director Community Programs and Services (DCP&S), Back Up Resident Assessment Instrument Coordinator (Back Up RAI Coordinator), Resident Council and Family Council Assistant, Maintenance Technicians, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted a tour of resident care area, observed the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, various licensee policies, procedures and programs, and resident and family council meeting minutes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (6)	CO #901	2018_776613_0002	613

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (6) Every licensee shall ensure that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except
(a) to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary; or
O. Reg. 79/10, s. 110 (6); O. Reg. 363/11, s. 9.

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 or section 36 of the Act: that the staff only apply the physical device that had been ordered or approved by a physician or registered nurse in the extended class.

Resident #003 was identified as having a daily restraint through the Resident Assessment Instrument-Minimum Data Set (RAI-MDS).

Inspector #613 observed resident #003 lying in bed with bed rails engaged on each day of the inspection. On October 1 and 2, 2018, resident #003 was observed to be sitting in a mobility device with a safety device applied.

During an interview with resident #003, they did not know why they had bed rails on their bed or why they had a safety device on their mobility aid.

A review of resident #003's current care plan identified conflicting interventions for the use of the bed rails. Under the foci titled, "transferring," the intervention identified, a specific number of bed rails up in bed. Under the foci titled, "ADL Functional Rehabilitation;" the intervention identified a different number of bed rails up to aid in bed mobility and safety. Under the foci titled, "Safety Devices/Restraints," the interventions identified, ensure that a specific number of bed rails are up when in bed, and also under the same foci, check that specific bed rails are up. The care plan identified for the safety device interventions under the foci titled, "Safety Devices/Restraints," to assess need for resident to require a safety device as a restraining device when in their mobility aid.

A review of the Doctor's Orders, identified, restraint type: a specific number of bed rails up. This form was not dated or signed by the physician to identify when the use of the bed rails were implemented. A physician's order dated on a specific date, identified, "stop putting bed rails up." There was no order for a safety device while in their mobility aid.

During an interview with RPN #103, they verified that the "Doctor's Orders" were not dated or signed by a doctor and stated that this form was usually completed by the doctor when a restraint was used.

A review of a form titled, "Consent for the Use of a Restraint or Personal Assistance Service Devices (PASD)," was in resident #003's chart and did not identify documentation to indicate the type of restraint or PASD, or consent from substitute decision-maker for use of a restraint or PASD and the sheet was not dated.

A review of the home's policy titled, " Minimizing Restraining of Residents: Use of Restraints - B-265" last revised April 2016, identified a physical restraint shall be applied only on the written order (or verbal order which is counter signed) of a physician or Registered Nurse Extended Class in collaboration with the interdisciplinary team. The written order is to include what device was being ordered and instructions relation to the use.

During an interview with RPN #101, they stated that when a specific number of bed rails were used on a resident's bed, they were considered a restraint. The RPN stated the resident now used a specific type and number of bed rails. RPN #101 stated that they did

not think that the safety device used when resident #003 was in their mobility aid was a restraint. RPN further stated they were unsure if resident #003 could undo the safety device or not.

During an interview with RPN #103, they stated that resident #003 used a specific number of bed rails for their safety, after a fall. RPN #103 further stated that during the next quarter, resident #003's cognitive status improved and the bed rails were reduced while in bed. The RPN stated that the safety device was not a restraint, but thought the resident could undo the restraint; however, they were unsure. The RPN reviewed the paper chart and confirmed there was no signed doctor's order in the physician notes for the use of the bed rails for a one month period and was unsure who had approved the use of the safety device.

During an interview with the Nurse Manager, they reviewed the resident's paper chart and confirmed that there was no signed doctors order for the use of the bed rails that were used for resident #003 for a one month period or the use of the safety device while the resident was in their mobility aid. [s. 110. (2) 1.]

2. The licensee has failed to ensure that no physical device was applied under section 31 of the Act to restrain a resident who was in bed, except to allow for a clinical intervention that required the resident's body or a part of the resident's body to be stationary.

During observations on October 3, 2018, Inspector #577 observed resident #004 to be lying in their bed with bed rails engaged and a specific restraint device applied to the resident that was attached to the bed and mattress.

A record review of resident #004's physician orders indicated restraint orders for bed rails and a specific restraint device to be secured around the resident's mattress and applied to the resident when in bed. A further review confirmed that the initial order for the specific restraint device was dated greater than one year earlier.

A record review of resident #004's care plan indicated the use of bed rails and a specific restraint device when they were in their bed.

During an interview with RPN #102, they reported to Inspector #577 that resident #004's specific restraint device was ordered a year ago as a safety measure.

During an interview with RPN #101, they reported that the specific restraint device was

ordered as a safety measure.

During an interview with Nurse Manager, they reported to Inspector #577 that resident #004 had a specific restraint device on when in bed, and it was applied as a safety measure. They further reported that the specific restraint device was to be attached to their bed. The Inspector discussed the legislation regarding not restraining residents in bed, except for clinical interventions. The Manager then removed the specific restraint device from resident #004. [s. 110. (6) (a)]

3. The licensee failed to ensure that for every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following was documented: all assessment, reassessment and monitoring, including the resident's response.

(A) During observations on October 3, 2018, Inspector #577 observed resident #004 to be lying in their bed with bed rails engaged and a specific restraint device attached to the resident, including their bed and mattress.

A review of resident #004's physician orders indicated restraint orders for the bed rails and a specific restraint device to the resident and secured around the resident's mattress, when in bed. A further review confirmed that the initial order for the specific restraint device was dated August 2016.

A review of resident #004's care plan indicated the use of the bed rails and a specific restraint device when they were in their bed.

The Inspector reviewed resident #004's Restraint Monitoring records for a four month period. The records for three months had not indicated the type of restraints to have been monitored; the last month of the review period had indicated a specific number of bed rails. A further review revealed inconsistent restraint monitoring documentation as follows:

-no documentation on 9 days in the first month of the review period, for specific times;
-no documentation on 4 days in the second month of the review period, for specific times;

-and no documentation on 8 days in the third month of the review period, for specific times.

A review of the home's policy titled, "Minimizing Restraining of Residents: Use of Restraints – B-265" revised April 2016, which indicated that staff were required to monitor the resident hourly and document re-assessments, repositioning, release and monitoring of the residents condition which included the resident's response on the Physical Restraint Monitoring Record.

During an interview with RPN #101 and RPN #103, they confirmed that the restraint monitoring record documentation for three months of the review period, was inconsistent and incomplete on many shifts.

During an interview with the Nurse Manager, they confirmed that the restraint documentation was inconsistent and had not included the assessment, reassessment and monitoring, and resident #004's response. They further confirmed that staff were required to document hourly on the restraint monitoring record and every eight hours, the registered staff were required to document their assessment and restraint effectiveness.

(B) Resident #002 was observed on October 2, 2018, as having a potential bed rail and safety device restraint.

On October 2 and 3, 2018, Inspector #577 observed resident #002 in their mobility aid with a safety device secured around them. On the afternoon of October 4, 2018, the resident was in their bed with bed rails engaged.

A review of resident #002's physician orders, indicated restraint orders for bed rails when in bed and a safety device to be applied when the resident was in their mobility aid.

A review of resident #002's care plan indicated the use of bed rails when they were in bed and a safety device when they were in their mobility aid.

Inspector #577 conducted a review of resident #002's Restraint Monitoring records for a four month period. The records for the first month of the review period had not indicated the type of restraints to have been monitored; there was not any restraint documentation dated for the second month of the review period; the third month of the review period indicated monitoring for bed rails and the final month of the review period indicated bed rails and safety device when in their mobility aid. A further review revealed inconsistent restraint monitoring documentation as follows:

-no documentation for 11 days in the first month of the review period;

-no documentation dated for the second month of the review period;
-and no documentation for 9 days in the third month of the review period.

During an interview with the Nurse Manager, they confirmed that the restraint documentation was inconsistent and had not included the assessment, reassessment and monitoring, and resident #002's response. They further confirmed that staff were required to document hourly on the restraint monitoring record and every eight hours, the registered staff were required to document their assessment and restraint effectiveness. [s. 110. (7) 6.]

Additional Required Actions:

CO # - 901 was served on the licensee. CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 following requirements were met where a resident was being restrained by a physical device under section 31 or section 36 of the Act: that the staff only apply the physical device that had been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each

resident that sets out clear directions to staff and other who provided direct care to the resident.

Resident #003 was identified as having a daily restraint through the Resident Assessment Instrument-Minimum Data Set (RAI-MDS).

Inspector #613 observed resident #003 lying in bed with bed rails engaged on each day of the inspection.

During an interview with resident #003, they did not know why they had bed rails on their bed.

A review of resident #003's current care plan identified conflicting interventions for the use of the bed rails. Under the foci titled, "transferring," the intervention identified, a specific number of bed rails up in bed. Under the foci titled, "ADL Functional Rehabilitation, " the intervention identified a different number of bed rails up to aid in bed mobility and safety. Under the foci titled, "Safety Devices/Restraints," the interventions identified, ensure that all bed rails are up when in bed, and also under the same foci, check that a specific number and type of bed rails are up.

A review of the reprinted kardex, identified that the specific number had been stroked out and written over to identify a different number of bed rails used daily.

A review of the "Doctors Orders", identified, restraint type: specific number of bed rails up. This form was not dated or signed by the physician. A physician's order identified, "stop putting bed rails up".

Inspector #613 reviewed a form titled, "Long-Term Care Consent for Bed Rails," which identified that resident #003's substitute decision-maker had consented to the use of specific number and type of bed rails.

A review of the home's policy titled, "Care Plans" last revised April 2016, identified that the licensee shall ensure that care plan sets out clear direction to staff and others who provide direct care to the resident.

During interviews with PSW #100, RPN #101 and RPN #103, they all stated that resident #003 used a specific number of bed rails while in bed for bed mobility and safety. PSW #100, RPN #101 and RPN #103 confirmed that resident #003's care plan did not provide

clear direction on the use of the bed rails.

During an interview with the Nurse Manager, they reviewed the residents care plan with the Inspector and confirmed that the care plan was unclear and had not been updated to the use of the bed rails. They further stated that there was conflicting information in the care plan, some areas stated a specific number of bed rails and others stated a different number of bed rails. [s. 6. (1) (c)]

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 there was a written plan of care for each resident that sets out clear directions to staff and other who provided direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

On October 3, 2018, at 1230 hrs, Inspector #577 reviewed the restraint monitoring records for residents #002 and #004 and found that RPN #101 had completed the restraint monitoring record for the entire shift.

During an interview with RPN #101, they reported to the Inspector that they had documented the restraint monitoring at 1200 hrs for the entire shift, as that was their routine.

During an interview with the Nurse Manager, Inspector #577 reviewed the restraint monitoring documentation for resident #002 and #004, with the Inspector and confirmed that the restraint monitoring documentation should have been completed at the time of the restraint assessment. [s. 231. (b)]

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 resident's written record was kept up to date at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, were kept closed and locked.

On October 1, 2018, at 1430 hours, Inspector #577 found an exit door at the end of the unit which led outside to a waterfront area, to be unlocked.

During an interview with the Nurse Manager, the Inspector showed them the unlocked door, and they reported that maintenance had been checking the sprinkler system and that was the explanation for the door being disabled.

On October 1, 2018, at 1530 hours, Inspector #577 found the exit door to be locked.

During an interview with Maintenance Technicians #105 and #106, they reported that on Monday October 1, 2018, an outside provider had been in the home and had conducted an annual inspection; which included checking the sprinkler system which had deactivated all of the locked doors for two hours. They confirmed that the Nurse Manager wasn't made aware prior or during the inspection, that the locked doors were deactivated. [s. 9. (1) 1. i.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-make, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Inspector #613 reviewed three of the home's medication incident reports. The Inspector noted that on all of the forms titled, "Medication Incident Report" that three out of three medication incident forms did not identify documentation that the medication incidents had been reported to the pharmacy service provider.

A review of the paper progress notes did not identify documentation to indicate that the medication incidents had been reported to the pharmacy service provider.

A review of the home's policy titled, "Medication Errors" last revised April 2016, identified that all medication errors and discrepancies must be reported on the incident report by the person discovering the incident and /or the staff involved, The resident and or substituted decision maker/next of kin, as well as the physician must be notified. The policy did not indicate that the pharmacy service provider was to be notified of the medication error.

During interviews with RPN #101 and RPN 103, both stated that they do not notify the pharmacy service provider of a medication error, unless the medication error was a result of the pharmacy service provider.

The Director of Community Programs and Services, who was the most Senior Manager working on October 4, 2018, reviewed the medication incident reports and the home's policy with the Inspector and stated that the pharmacy service provider was not notified of medication errors as they happened. They further stated that the Medication Incident Report and the policy and procedure would have to be updated. [s. 135. (1)]

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*

Issued on this 26th day of November, 2018

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

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613)
Inspection No. / No de l'inspection :	2018_776613_0002
Log No. / No de registre :	013075-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 15, 19, 2018
Licensee / Titulaire de permis :	Santé Manitouwadge Health 1 Health Care Crescent, MANITOUWADGE, ON, P0T-2C0
LTC Home / Foyer de SLD :	Santé Manitouwadge Health 1 Health Care Crescent, MANITOUWADGE, ON, P0T-2C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jocelyn Bourgoin

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To Santé Manitouwadge Health, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (6) Every licensee shall ensure that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except
(a) to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary; or
(b) if the physical device is a bed rail used in accordance with section 15. O. Reg. 79/10, s. 110 (6); O. Reg. 363/11, s. 9.

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s. 110. (6).

Specifically, the licensee must:

a) Immediately take steps to ensure that no application of any physical device to restrain a resident in bed is utilized, except to allow for a clinical intervention that required the resident's body or a part of the resident's body to be stationary.

b) Immediately ensure that interdisciplinary staff who are responsible for the implementation of the aforementioned restraint devices are aware the issuance of this order, and the need to cease their inappropriate application.

Grounds / Motifs :

1. The licensee has failed to ensure that no physical device was applied under section 31 of the Act to restrain a resident who was in bed, except to allow for a clinical intervention that required the resident's body or a part of the resident's body to be stationary.

During observations on October 3, 2018, Inspector #577 observed resident #004 to be lying in their bed with bed rails engaged and a specific restraint device applied to the resident that was attached to the bed and mattress.

A record review of resident #004's physician orders indicated restraint orders for bed rails and a specific restraint device to be secured around the resident's mattress and applied to the resident when in bed. A further review confirmed that the initial order for the specific restraint device was dated greater than one year earlier.

A record review of resident #004's care plan indicated the use of bed rails and a specific restraint device when they were in their bed.

During an interview with RPN #102, they reported to Inspector #577 that resident #004's specific restraint device was ordered a year ago as a safety measure.

During an interview with RPN #101, they reported that the specific restraint device was ordered as a safety measure.

During an interview with Nurse Manager, they reported to Inspector #577 that resident #004 had a specific restraint device on when in bed, and it was applied as a safety measure. They further reported that the specific restraint device was to be attached to their bed. The Inspector discussed the legislation regarding not restraining residents in bed, except for clinical interventions. The Manager then removed the specific restraint device from resident #004. (613)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee must be compliance with r. 110. (7) 6. of the LTCHA.

Specifically the licensee must ensure that every use of a physical device to restrain a resident is documented, including all assessments, reassessments and monitoring, including the residents' response.

Grounds / Motifs :

1. The licensee failed to ensure that for every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following was documented: all assessment, reassessment and monitoring, including the resident's response.

(A) During observations on October 3, 2018, Inspector #577 observed resident

#004 to be lying in their bed with bed rails engaged and a specific restraint device attached to the resident, including their bed and mattress.

A review of resident #004's physician orders indicated restraint orders for the bed rails and a specific restraint device to the resident and secured around the resident's mattress, when in bed. A further review confirmed that the initial order for the specific restraint device was dated August 2016.

A review of resident #004's care plan indicated the use of the bed rails and a specific restraint device when they were in their bed.

The Inspector reviewed resident #004's Restraint Monitoring records for a four month period. The records for three months had not indicated the type of restraints to have been monitored; the last month of the review period had indicated a specific number of bed rails. A further review revealed inconsistent restraint monitoring documentation as follows:

-no documentation on 9 days in the first month of the review period, for specific times;
-no documentation on 4 days in the second month of the review period, for specific times;
-and no documentation on 8 days in the third month of the review period, for specific times.

A review of the home's policy titled, "Minimizing Restraining of Residents: Use of Restraints – B-265" revised April 2016, which indicated that staff were required to monitor the resident hourly and document re-assessments, repositioning, release and monitoring of the residents condition which included the resident's response on the Physical Restraint Monitoring Record.

During an interview with RPN #101 and RPN #103, they confirmed that the restraint monitoring record documentation for three months of the review period, was inconsistent and incomplete on many shifts.

During an interview with the Nurse Manager, they confirmed that the restraint documentation was inconsistent and had not included the assessment, reassessment and monitoring, and resident #004's response. They further

confirmed that staff were required to document hourly on the restraint monitoring record and every eight hours, the registered staff were required to document their assessment and restraint effectiveness.

(B) Resident #002 was observed on October 2, 2018, as having a potential bed rail and safety device restraint.

On October 2 and 3, 2018, Inspector #577 observed resident #002 in their mobility aid with a safety device secured around them. On the afternoon of October 4, 2018, the resident was in their bed with bed rails engaged.

A review of resident #002's physician orders, indicated restraint orders for bed rails when in bed and a safety device to be applied when the resident was in their mobility aid.

A review of resident #002's care plan indicated the use of bed rails when they were in bed and a safety device when they were in their mobility aid.

Inspector #577 conducted a review of resident #002's Restraint Monitoring records for a four month period. The records for the first month of the review period had not indicated the type of restraints to have been monitored; there was not any restraint documentation dated for the second month of the review period; the third month of the review period indicated monitoring for bed rails and the final month of the review period indicated bed rails and safety device when in their mobility aid. A further review revealed inconsistent restraint monitoring documentation as follows:

-no documentation for 11 days in the first month of the review period;
-no documentation dated for the second month of the review period;
-and no documentation for 9 days in the third month of the review period.

During an interview with the Nurse Manager, they confirmed that the restraint documentation was inconsistent and had not included the assessment, reassessment and monitoring, and resident #002's response. They further confirmed that staff were required to document hourly on the restraint monitoring record and every eight hours, the registered staff were required to document their assessment and restraint effectiveness.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as it related to two out of three residents reviewed. The home had a level 3 history as they had one or more related non-compliance with this section of the LTCHA that included:
-Voluntary Plan of Correction (VPC) issued August 2, 2017 (2017_435621_0019).

(613)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 14, 2018

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:

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

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 15th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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