Ontario

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

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

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

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


**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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 13, 2018 | 2018_725522_0010 | 017608-18 | Critical Incident System |

### Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive ST. THOMAS ON N5R 5V1

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

Terrace Lodge
475 Talbot Street East, 49462 Talbot Line AYLMER ON N5H 3A5

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

JULIE LAMPMAN (522)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): July 16, 17, 18, 20, and 24, 2018.**

**A Critical Incident System report related to an incident involving a resident was inspected during this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Homes, the Manager of Resident Care, the Resident Care Coordinator, the Manager of Support Services, a Physician, the Investigating Coroner, a Detective with the Ontario Provincial Police, an Occupational Therapist, Registered Practical Nurses, Personal Support Workers and a family member.**

**During the course of the inspection, the inspector observed staff and resident interactions, observed the application of seat belt restraints, reviewed resident clinical records, investigative notes, training records, meeting minutes, and relevant policies and procedures.**

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

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

- **5 WN(s)**
- **2 VPC(s)**
- **3 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 | Legendé<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. |

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,**
**(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;**
**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;**
**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**
**(d) that the changes or improvements under clause (b) are promptly implemented; and**
**(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act was undertaken on a monthly basis.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care regarding an incident involving an identified resident.

In an interview, the Resident Care Coordinator (RCC) stated that they conducted monthly audits of the use of restraints focusing on a specific resident home area each month. The RCC stated that an audit was not completed monthly of all restraints used.

In an interview, the Manager of Resident Care (MRC) stated that the monthly analysis of the use of restraints occurred at the home's monthly Continuous Quality Improvement (CQI) meetings and was based on the audits completed by the RCC.

Review of the Homes and Seniors Services CQI team minutes for 2018 noted the following:

January 10, 2018 - "Restraints Update: Progress has been made on UN. They are now down to 4 restraints after review and education. The team will be moving to US to start on reduction on that unit later this month by holding weekly restraint meetings."
February 7, 2018 – There was no documented analysis of restraints.
March 7, 2018 - There was no documented analysis of restraints.
May 2, 2018 - There was no documented analysis of restraints.
June 16, 2018 - There was no documented analysis of restraints.
July 4, 2018 - "Restraints currently at 20 restraint a reduction from 42. There are 13 wander guards in place and 40 PASDs. Not all the new bed rails are captured in these statistics yet."

There were no documented meeting minutes for the month of April 2018.

In an interview, the MRC acknowledged that the analysis of restraints was not captured in the monthly CQI minutes. The MRC stated the CQI team had discussion based on the audit completed by the RCC and only put the number of restraints in the minutes.

In an interview, the Administrator acknowledged that the minutes did not capture a monthly analysis of the use of restraints.

The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act was undertaken on a monthly basis. [s. 113. (a)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

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

**s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:**
**1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
**2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
**3. Behaviour management. 2007, c. 8, s. 76. (7).**
**4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
**5. Palliative care. 2007, c. 8, s. 76. (7).**
**6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 4. How to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations.

Ontario Regulation 79/10, 221 (2) states, "The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1.Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act."

During interviews with direct care staff, including Personal Support Workers and Registered Practical Nurses, four out of 10 (40%) direct care staff stated they had not received training in the use of restraints.

A review of Surge Learning for 2017 noted that 66 of 75 (88%) direct care staff had completed training on minimizing of restraining.

In an interview, the Administrator and the Manager of Resident Care indicated that all direct care staff should have received annual training on the minimizing of restraining.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
4. How to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations. [s. 76. (7) 4.]

2. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
6. Any other area provided for in the regulations.

Ontario Regulation 79/10 s. 221. (1) states, "For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6.For staff who apply Personal Assistance Services Devices (PASDs) or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs"

In an interview, the Administrator stated that staff completed training on the minimizing of restraining on Surge learning which was interactive eLearning that consisted of a video, review of policy, restraints and PASDs and a quiz.

Review of the home's policy Restraints: Minimizing Restraining of Residents: Use of Restraints and PASDs revision date: December 2017, noted the following:

"Orientation and training includes the following:
Staff and contractors who provide direct care to residents must receive orientation and annual retraining on minimizing of restraining of residents.
1. Registered staff orientated and trained using the homes orientation presentation.
2. Hands on instruction and practice on correct use of physical restraints.
3. Other deemed as necessary by the home."

In an interview, the Administrator confirmed that staff did not receive hands on training on the application and use of restraints.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other area provided for in the regulations. [s. 76. (7) 6.]

***Additional Required Actions:***

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

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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**

**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 of the Act: That the resident was 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, and that the resident was released from the physical device and repositioned at least once every two hours.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care regarding an incident involving an identified resident.

In an interview, two personal support workers (PSWs) stated at a specific time period, they had repositioned the identified resident but had not released or checked the physical device that was applied to the resident.

In an interview, a PSW stated at a specific time period they had checked the identified resident's physical device and ensured it was applied appropriately but they did not release the resident's physical device.

In an interview, the Administrator stated that staff should be physically checking a resident's physical device every hour and that the resident should be released from the physical device every two hours, especially if the resident was being repositioned.

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 of the Act: That the resident was 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, and that the resident was released from the physical device and repositioned at least once every two hours.

2. The licensee has failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: Staff applied the physical device in accordance with any manufacturer’s instructions.

A random observation of three resident’s on a specified resident home area with the Manager of Resident Care (MRC) noted the following:

Two identified residents were observed with a physical device applied. The inspector observed the physical devices to be applied inappropriately. The MRC reapplied the identified residents' physical devices appropriately.

In an interview, the MRC acknowledged that both identified residents' physical devices were not applied appropriately.

The licensee has failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: Staff applied the physical device in accordance with any manufacturer’s instructions.

3. The licensee has failed to ensure that the resident's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or 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 based on the resident's condition or circumstances.

A random observation of three residents on a specified resident home area with the Manager of Resident Care noted that two identified residents had physical devices in place that were not applied appropriately.

In an interview, a Registered Practical Nurse (RPN) stated that registered staff documented once a shift on the Treatment Administration Record (TAR) that residents'

physical devices have been checked. The RPN stated they completed a visual check of the physical device and the personal support worker (PSW) physically checked the physical device. The RPN stated if there were any issues with a resident's physical device the PSW should inform the registered staff.

In an interview, another RPN stated they would observe a resident's physical device to ensure the device was applied appropriately.

In an interview, the MRC stated registered staff should physically check the effectiveness of the physical device for each resident when they documented in the TAR.

The licensee has failed to ensure that the resident's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or 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 based on the resident's condition or circumstances. [s. 110.]

***Additional Required Actions:***

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

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Long-Term Care Homes Act 2007, S.O. 2007, c. 8 s. 8 (1) (a) states, "Every licensee of a long-term care home shall ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents."

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care regarding an incident involving an identified resident.

Review of an identified home policy noted how staff should have handled the incident with the identified resident.

A review of the CIS report, investigative notes and interviews with registered staff and PSWs noted that staff did not follow the home's policy regarding the incident with the identified resident.

In an interview, the MRC #101 acknowledged that staff did not comply with the identified home policy.

The licensee has failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy, was complied with. [s. 8. (1) (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD**

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

**s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,**
**(a) is well maintained; O. Reg. 79/10, s. 111. (2).**
**(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).**
**(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a Personal Assistance Services Device (PASD) used under section 33 of the Act,
(a) is well maintained;
(b) is applied by staff in accordance with any manufacturer's instructions; and
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions.

A random observation of three residents on a specified resident home area with the Manager of Resident Care noted the following:

An identified resident was observed with a PASD in place. The PASD was noted to be altered and not well maintained.

In an interview, the MRC acknowledged that the identified resident's PASD was altered and not well maintained.

The licensee has failed to ensure that ensure that a PASD used under section 33 of the Act,
(a) is well maintained;
(b) is applied by staff in accordance with any manufacturer's instructions; and
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. [s. 111. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a Personal Assistance Service Device (PASD) used under section 33 of the Act,***
***(a) is well maintained;***
***(b) is applied by staff in accordance with any manufacturer's instructions; and***
***(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions, to be implemented voluntarily.***

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**Issued on this 27th day of September, 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

**Ministére 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) :** | JULIE LAMPMAN (522) |
| **Inspection No. / No de l'inspection :** | 2018_725522_0010 |
| **Log No. / No de registre :** | 017608-18 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Sep 13, 2018 |
| **Licensee / Titulaire de permis :** | The Corporation of the County of Elgin Municipal Homes<br>450 Sunset Drive, ST. THOMAS, ON, N5R-5V1 |
| **LTC Home / Foyer de SLD :** | Terrace Lodge<br>475 Talbot Street East, 49462 Talbot Line, AYLMER, ON, N5H-3A5 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Lisa Penner |

To The Corporation of the County of Elgin Municipal Homes, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 113. Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared.
O. Reg. 79/10, s. 113.

**Order / Ordre :**

The licensee must be compliant with s. 113 (a) of O. Reg. 79/10:

Specifically the licensee must ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis.

**Grounds / Motifs :**

1. The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act was undertaken on a monthly basis.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care regarding an incident involving an identified resident.

In an interview, the Resident Care Coordinator (RCC) stated that they conducted monthly audits of the use of restraints focusing on a specific resident home area each month. The RCC stated that an audit was not completed monthly of all restraints used.

In an interview, the Manager of Resident Care (MRC) stated that the monthly analysis of the use of restraints occurred at the home's monthly Continuous Quality Improvement (CQI) meetings and was based on the audits completed by the RCC.

Review of the Homes and Seniors Services CQI team minutes for 2018 noted the following:
January 10, 2018 - "Restraints Update: Progress has been made on UN. They are now down to 4 restraints after review and education. The team will be moving to US to start on reduction on that unit later this month by holding weekly restraint meetings."
February 7, 2018 - There was no documented analysis of restraints.
March 7, 2018 - There was no documented analysis of restraints.
May 2, 2018 - There was no documented analysis of restraints.
June 16, 2018 - There was no documented analysis of restraints.
July 4, 2018 - "Restraints currently at 20 restraint a reduction from 42. There are 13 wander guards in place and 40 PASDs. Not all the new bed rails are captured in these statistics yet."

There were no documented meeting minutes for the month of April 2018.

In an interview, the MRC acknowledged that the analysis of restraints was not captured in the monthly CQI minutes. The MRC stated the CQI team had discussion based on the audit completed by the RCC and only put the number of restraints in the minutes.

In an interview, the Administrator acknowledged that the minutes did not capture a monthly analysis of the use of restraints.

The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act was undertaken on a monthly basis.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 3 as it related to 7 out of 7 months reviewed. The home had a level 2 history of unrelated non-compliance.
(522)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 13, 2018

**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. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

**Order / Ordre :**

The licensee must be compliant with s. 76. (7) of the LTCHA:

• Specifically the licensee must ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.

• The training must include the application of physical devices and personal assistance services devices.

**Grounds / Motifs :**

1. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 4. How to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations.

During interviews with direct care staff, including Personal Support Workers and

Registered Practical Nurses, four out of 10 (40%) direct care staff stated they had not received training in the use of restraints.

A review of Surge Learning for 2017 noted that 66 of 75 (88%) direct care staff had completed training on minimizing of restraining.

In an interview, the Administrator and the Manager of Resident Care indicated that all direct care staff should have received annual training on the minimizing of restraining.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 4. How to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations.

2. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
6. Any other area provided for in the regulations.

Ontario Regulation 79/10 s. 221. (1) states, "For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6.For staff who apply Personal Assistance Services Devices (PASDs) or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs"

In an interview, the Administrator stated that staff completed training on the minimizing of restraining on Surge learning which was interactive eLearning that consisted of a video, review of policy, restraints and PASDs and a quiz.

Review of the home's policy Restraints: Minimizing Restraining of Residents: Use of Restraints and PASDs revision date: December 2017, noted the

following:

"Orientation and training includes the following:
Staff and contractors who provide direct care to residents must receive orientation and annual retraining on minimizing of restraining of residents.
1. Registered staff orientated and trained using the homes orientation presentation.
2. Hands on instruction and practice on correct use of physical restraints.
3. Other deemed as necessary by the home."

In an interview, the Administrator confirmed that staff did not receive hands on training on the application and use of restraints.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
6. Any other area provided for in the regulations.

The severity of this issue was determined to be a level 3 as there was Actual Harm/Risk to the resident. The scope of the issue was a level 1 as it related to one area of training. The home had a level 3 history of non-compliance with this section of the LTCHA that included a Voluntary Plan of Correction (VPC) issued April 5, 2016 (2016_262523_0015).
(522)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 13, 2018

**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

**Order / Ordre :**

The licensee must be compliant with s. 110 of O. Reg. 79/10:

Specifically the licensee must ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
a) Staff apply physical devices to the identified residents and any other resident in accordance with any manufacturer's instructions;
b) 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;
c) That the resident is released from the physical device and repositioned at least once every two hours;
d) 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.

**Grounds / Motifs :**

1. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care regarding an incident involving an identified resident.

In an interview, two personal support workers (PSWs) stated at a specific time period, they had repositioned the identified resident but had not released or checked the physical device that was applied to the resident.

In an interview, a PSW stated at a specific time period they had checked the identified resident's physical device and ensured it was applied appropriately but

they did not release the resident's physical device.

In an interview, the Administrator stated that staff should be physically checking a resident's physical device every hour and that the resident should be released from the physical device every two hours, especially if the resident was being repositioned.

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 of the Act: That the resident was 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, and that the resident was released from the physical device and repositioned at least once every two hours.

2. The licensee has failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: Staff applied the physical device in accordance with any manufacturer's instructions.

A random observation of three resident's on a specified resident home area with the Manager of Resident Care (MRC) noted the following:

Two identified residents were observed with a physical device applied. The inspector observed the physical devices to be applied inappropriately. The MRC reapplied the identified residents' physical devices appropriately.

In an interview, the MRC acknowledged that both identified residents' physical devices were not applied appropriately.

The licensee has failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: Staff applied the physical device in accordance with any manufacturer's instructions.

3. The licensee has failed to ensure that the resident's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or 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

based on the resident's condition or circumstances.

A random observation of three residents on a specified resident home area with the Manager of Resident Care noted that two identified residents had physical devices in place that were not applied appropriately.

In an interview, a Registered Practical Nurse (RPN) stated that registered staff documented once a shift on the Treatment Administration Record (TAR) that residents' physical devices have been checked. The RPN stated they completed a visual check of the physical device and the personal support worker (PSW) physically checked the physical device. The RPN stated if there were any issues with a resident's physical device the PSW should inform the registered staff.

In an interview, another RPN stated they would observe a resident's physical device to ensure the device was applied appropriately.

In an interview, the MRC stated registered staff should physically check the effectiveness of the physical device for each resident when they documented in the TAR.

The licensee has failed to ensure that the resident's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or 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 based on the resident's condition or circumstances.

The severity of this issue was determined to be a level 3 as there was Actual Harm/Risk to the resident. The scope of the issue was a level 2 as it related to 2 out of 3 physical restraints reviewed. The home had a level 3 history of non-compliance with this section of O. Reg. 79/10 that included a Voluntary Plan of Correction (VPC) issued November 27, 2017 (2017_674610_0007). (522)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 12, 2018

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

**Ministére 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

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

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)<br>151, rue Bloor Ouest, 9e étage<br>Toronto ON  M5S 2T5 | Directeur<br>a/s du coordonnateur/de la coordonnatrice en matière d'appels<br>Direction de l'inspection des foyers de soins de longue durée<br>Ministère de la Santé et des Soins de longue durée<br>1075, rue Bay, 11e étage<br>Toronto ON  M5S 2B1<br>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 13th day of September, 2018**

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

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

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

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

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

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