Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
October 27, 29, 2010	2010-173-2908-27Oct103825 2010-192-2908-25Oct140703	Complaint – H00802, H00880

Licensee/Titulaire
Regency LTC Operating Limited Partnership On.
100 Milverton Drive, Suite 700, Mississauga, Ont., L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée
The Waterford Nursing Home
2140 Baronwood Drive, Oakville, Ontario L6M 4V6

Name of Inspector(s)/Nom de l'inspecteur(s)
Lesa Wulff – #173 – LTC Inspector – Nursing, Debora Saville - #192 – LTC Inspector – Nursing

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct two complaint inspections related to restraints.

During the course of the inspection, the inspectors spoke with: Administrator, Co-Director of Cares (2), RAI-MDS Coordinator, Residents, Registered Staff, Personal Support Workers

During the course of the inspection, the inspectors: Observed care of Residents, interviewed Residents, interviewed staff, reviewed policy and procedures, reviewed staff education. reviewed clinical records

The following Inspection Protocols were used during this inspection:
Minimizing Restraints Inspection Protocol.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

8 WN
4 VPC
3 CO'S – CO# 001, CO#002, CO#003

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.31(2)5
The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
(5)The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Findings:

1. An identified resident was observed to be wearing a rear closing table tray for two days during this inspection. No consent for restraint was found for this resident in the clinical record.

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WN #2: The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s. 6(1)c
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. The written plan of care for an identified resident does not include the risk behaviour that requires the resident to have a restraint applied. Staff indicated that this is used for positioning at meals. This information is not on the plan of care and does not include interventions that give clear direction to staff related to care needs as a result of the restraint.

2. The written plan of care for an identified resident does not include the risk behaviour that requires the

use of a restraint. The restraint assessment completed indicates that this resident will slide in the wheelchair and thus requires a table tray. This information was not included in the written plan of care with interventions related to this restraint and does not give clear direction to staff related to care needs as a result of the restraint.

3. The written plan of care for an identified resident does not include the risk behaviour that requires the use of a restraint. The resident is presently using a front closing seat belt. The restraint assessment completed on September, 2010 indicates that the resident will attempt to self ambulate. The Resident Assessment Protocol (RAP) completed on September, 2010 indicates that this behaviour no longer exists but the restraint is in place at the family request. This information was not included in the written plan of care with interventions related to this restraint and does not give clear direction to staff related to care needs as a result of the restraint.
4. The written plan of care for an identified resident does not include the risk behaviour that requires the use of a restraint. The restraint assessment completed October, 2010 indicates that the resident will attempt to self transfer and requires the table tray. Resident Assessment Protocol (RAP) states that the resident has a history of frequent attempts to get out of the wheelchair to self transfer and ambulate. This information was not included in the written plan of care with interventions related to this restraint and does not give clear direction to staff related to care needs as a result of the restraint.
5. The written plan of care for an identified resident does not include the risk behaviour that requires the use of a restraint. The restraint assessment completed on August, 2010 indicates that the resident attempts to self transfer. The Resident Assessment Protocol (RAP) completed on August, 2010 states that the resident still believes that the resident can transfer from the wheelchair without asking for assistance. This information was not included in the written plan of care with interventions related to this restraint and does not give clear direction to staff related to care needs as a result of the restraint.

	#173

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 related to developing a process to ensure that each plan of care sets out clear direction to staff who provide direct care to the resident, to be implemented voluntarily.

WN #3: The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s. 6(7)
The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:

1. Written plan of care for two identified residents indicates that the residents are to have the restraint released and be repositioned every two hours while restraint is applied. These residents were monitored on the home area for a period of two hours. These residents were not approached by staff and the restraints released and did not receive repositioning during this time period. At the end of this time period these residents were taken from the lounge area and transported to the dining room for lunch.
2. Written plan of care for an identified resident indicates that the resident is to have the restraint released and be repositioned every two hours while restraint is applied. This resident was monitored

on the home area for period of two hours. The resident was not approached by staff; the restraint not released and did not receive repositioning during this time period.

3. Written plan of care for an identified resident indicates that the resident is to have the restraint released and be repositioned every two hours while restraint is applied. This resident was monitored on the home area for period of two hours. The resident was not released from the restraint or repositioned during the observation period.

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C/O # 001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form

WN #4: The licensee has failed to comply with O.Reg 79/10 s.110(1)1
Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
(1) Staff applies the physical device in accordance with any manufacturer's instructions.

Findings:

1. During the inspection in the home, several residents were identified as having seat belts restraints that were not applied effectively. During interview with the Director of Care on October 29, 2010, the Director was asked to explain the expectation of the home related to the application of restraints. The Director of care stated that the expectation of the home was that there was no more than a two finger gap between the resident and the seat belt when the seat belt was applied.
2. An identified resident was observed with a seat belt on (front closing). The resident was unable to undo the seatbelt when requested. The seat belt was noted to be 2 inches too loose in application.
3. An identified resident was observed having a seatbelt restraint in place. The resident was not able to undo the seatbelt when writer asked two times. The seatbelt was too loose with a 3 inch gap between the resident and the belt.
4. An identified resident was observed with the rear closing table tray on with one side pushed forward and the other side close to the resident. This was left in this position for approximately 1 hour before staff corrected the positioning of the table tray.
5. An identified resident was observed with a front closing seat belt (fastex) restraint sitting loosely on the lap. The resident was not able to undo the seatbelt. There was approximately 5 inches between the belt and the resident's abdomen.
6. An identified resident was observed on sitting in the lounge. The front closing seat belt was secured loosely on the lap. The resident was unable to undo the seatbelt.
7. An identified resident was again observed with front closing seat belt secured loosely in the lap with approximately 5 inches between the belt and the resident's abdomen.

Inspector ID #:	# 173 and # 192

Additional Required Actions:

C/O # 002 will be served on the licensee. Refer to the "Order(s) of the Inspector" form

WN #5: The licensee has failed to comply with O.Reg 79/10 s.110(2)1
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.

Findings:

1. An identified resident was observed to be wearing a rear closing table tray on two days during this inspection. No physicians order for a table tray restraint was found in the clinical record.
2. An identified resident was observed in the lounge area of a resident home area. The resident was noted to have a front closing seatbelt in place. When approached, the resident was asked if the resident could undo the belt. The resident attempted two times but was unsuccessful. Two staff members were approached and asked if the seatbelt on the resident was a restraint. They stated that it was not. Writer asked the staff, "what if the resident was unable to undo the belt?" the staff member stated, "then yes it is, but we have no papers for her". The staff members stated that the belt has always been on, but they did not think of it as a restraint. Upon review of the clinical record, there is no order, assessment, consent, or plan of care in place for this restraint.
3. An identified resident was observed in the lounge area on a resident home area. The resident was noted to have a front closing seatbelt in place. Writer approached the resident and asked her to undo the belt. The resident was unable to understand the question or undo the belt. Upon review of the clinical record, the resident is a new admission to the home. Staff member stated that she gave care to the resident that morning and applied the seatbelt "because it was there". She did not know if the seatbelt was required or not. Neither staff was aware that the resident could not undo the belt.
4. An identified resident was to have a front closing seatbelt and table top on at all times while up in the wheelchair. It is documented that the resident sustained a fall in the resident's room. The resident was found in front of the wheelchair lying on the resident's right side. It is unclear if the restraint was applied.
5. An identified residents progress notes indicate that there was "application of a restraint without family consent and MD order".

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C/O # 003 will be served on the licensee. Refer to the "Order(s) of the Inspector" form

WN #6: The licensee has failed to comply with O.Reg 79/10 s.110(2)4
Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
(4)That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)

Findings:

1. An identified resident was in the lounge area in full view of writer for a period in excess of 2 hours. The resident was not approached by staff, restraint released and resident repositioned for this time period. The resident was taken from the lounge area to the dining room without repositioning at that time. Documentation by the staff indicated that the resident was repositioned. Resident was in full view of writer during this time period, and this care did not occur.
2. An identified resident was observed for a period in excess of 2 hours. No staff member approached the resident, released the restraint or repositioned the resident for this time period. Staff documented on the restraint flowsheet that resident was repositioned. Resident was in full view of writer during this time period, and this care did not occur.
3. An identified resident was monitored for period of 2 hours. During this period no staff member released the restraint or repositioned the resident. Staff documented on the Restraint Monitoring Record that the resident was repositioned. Resident was in full view of the writer during this time period, and this care did not occur.
4. An identified resident was monitored for period of 2 hours. During this period no staff member released the restraint or repositioned the resident. Resident was in full view of the writer during this time period.

Inspector ID #:	#173 and #192

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 related to ensuring that resident's restraint is released and the resident repositioned every two hours to be implemented voluntarily.

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

Findings:

1. Flowsheets for the restraint were reviewed for an identified resident, there were 20 missing shift signatures by registered staff for this resident for the month of October in the area provided to

document reassessment for the continued need of the restraint prior to application.

2. Flowsheets for restraint were reviewed for an identified resident, there were 17 missing shift signatures by registered staff for this resident in the month of October on the flowsheet in the area provided to document reassessment for the continued need of the restraint prior to application.
3. During interview with Registered Practical Nurse (RPN), the staff member indicated that a signature on the flowsheet indicated that the staff member was reviewing the correct application of the restraint as well as that the correct care had been provided to the resident. The staff member was unaware that the signature was to indicate that the resident had been reassessed and that the restraint was still required as per restraint policy NUR-V-132. The staff member indicated in the interview that signing the flowsheet was done with the assumption that care had been provided as documented, and this was not something that the staff member was monitoring regularly.
4. The Restraint Monitoring Record for an identified resident was reviewed, there were no signatures indicating that the resident had been reassessed for the application of a restraint every eight hours as indicated below.
   September 2010 - front closing seat belt - 21/30 times on days, 18/30 times on evenings.
   - Table top - 19/30 times on days, 18/30 times on evenings.
5. The Restraint Monitoring Record for an identified resident was reviewed; there were no signatures indicating that the resident had been reassessed for the application of a restraint every eight hours as indicated below.
   September 2010 – front closing seat belt - 12/27 times on day shift, 22/27 times on evening shift.
   October 17 - 26, 2010 - 3/10 on the day shift, 4/10 on the evening shift.
6. The Restraint Monitoring Record for an identified resident was reviewed: there were no signatures indicating that the resident had been reassessed for the application of a restraint every eight hours as indicated below.
   August 2010 - 10/31 times on days, 14/31 times on evenings.
   September 2010 - 3/31 on days, 22/31 times on evenings.
7. The Restraint Monitoring Record for an identified resident was reviewed; there were no signatures indicating that the resident had been reassessed for the application of a restraint every eight hours as indicated below.
   October 17 – 26, 2010 – 7/10 times on days shift, 3 of 10 times on evening shift.

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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 related to developing a process to ensure that all residents in restraints are reassessed and the effectiveness of the restraint reevaluated every 8 hours or at any other time based on the residents condition and circumstances, to be implemented voluntarily.

WN #8: The licensee has failed to comply with O.Reg 79/10 s.110(7)2
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:
(2) What alternatives were considered and why those alternatives were inappropriate.

Findings:

1. Restraint assessment completed for 5 residents reviewed, indicates several alternatives that were tried and unsuccessful, however the reason that they were unsuccessful is not identified.
2. Assessments reviewed for 2 residents reviewed and noted to have seatbelt restraints, had alternatives such as side rails and hi/lo beds checked as alternatives. These items are not alternatives to a seatbelt restraint.
3. Assessment reviewed for 2 residents reviewed, had the reason that alternatives were unsuccessful listed as POA requests present restraint, this response does not provide a rationale as to why alternatives were unsuccessful

Inspector ID #:	#173

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 related to developing a process to ensure that documentation occurs when alternatives to restraints are considered and why those alternatives were inappropriate, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Apr 27/11

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Lesa Wulff	**Inspector ID #**	#173
Log #:	H00802, H00880		
Inspection Report #:	2010-192-2908-25Oct140703 2010-173-2908-27Oct103825		
Type of Inspection:	Complaint Log #H00802, H00880		
Date of Inspection:	Oct 27, 29, 2010		
Licensee:	Regency LTC Operating Limited Partnership On. 100 Milverton Drive, Suite 700, Mississauga, Ont., L5R 4H1		
LTC Home:	The Waterford Nursing Home 2140 Baronwood Drive, Oakville, Ontario L6M 4V6		
Name of Administrator:	Eileen Trevors		

To Regency LTC Operating Limited Partnership On, you are hereby required to comply with the following orders by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s. 6(7)
6(7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Order:

1. **The licensee will ensure that care is provided to four (4) identified residents as outlined in the plan of care, which includes releasing the restraint and repositioning these residents every two hours.**
2. **The licensee will provide education to all staff in the home related to LTCHA 2007 s.110(2)4 that states that the resident is released from the physical device and repositioned at least once every two hours.**

Grounds:

1. Written plan of care for two identified residents indicates that the residents are to have the restraint released and be repositioned every two hours while restraint is applied. These residents were monitored on the home area for a period of two hours. These residents were not approached by

staff and the restraints were not released and did not receive repositioning during this time period. At the end of this time period these residents were taken from the lounge area and transported to the dining room for lunch.

2. Written plan of care for an identified resident indicates that the resident is to have the restraint released and be repositioned every two hours while restraint is applied. This resident was monitored on the home area for period of two hours. The resident was not approached by staff; the restraint not released and did not receive repositioning during this time period.
3. Written plan of care for an identified resident indicates that the resident is to have the restraint released and be repositioned every two hours while restraint is applied. This resident was monitored on the home area for period of two hours. The resident was not released from the restraint or repositioned during the observation period.

This order must be complied with by:	Immediately

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(b)

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

Order:

1. **The licensee will ensure that five (5) identified residents, currently in restraints are reassessed to ensure application of the restraint according to manufacturers instructions. The application will be corrected as required.**
2. **The licensee will develop a process to ensure the continued application of a restraint according to manufacturer's instructions for all residents currently in restraints in the home.**

Grounds:

1. Five (5) identified residents were observed to have seatbelt restraints in place that were too loose and inappropriately applied.

This order must be complied with by:	Immediately

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: The licensee has failed to comply with O.Reg 79/10 s.110(2)1
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.

Order:

1. **The licensee will ensure that five (5) identified residents have a restraint in place only if the physical device has been ordered or approved by a physician or registered nurse in the extended class.**
2. **The licensee will develop a process to ensure a restraint is not applied unless ordered or approved by a physician or registered nurse in the extended class.**

Grounds:

1. Five (5) identified residents were noted during this inspection to have had a restraint applied without a clinical assessment, determined need, order or consent for a restraint.

This order must be complied with by:	Immediately

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 4th day of Feb. , 2011.	
Signature of Inspector:	Lesa Wulff
Name of Inspector:	LESA WULFF
Service Area Office:	HAMILTON SERVICE AREA OFFICE