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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 29, 2015	2015_205129_0003	H-000961-14	Complaint

Licensee/Titulaire de permis

BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED
600 Lake Street St. Catharines ON L2N 4J4

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

HEIDEHOF LONG TERM CARE HOME
600 Lake Street St. Catharines ON L2N 4J4

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 18, 19 and 20, 2015

During the course of the inspection, the inspector(s) spoke with residents and resident's family members, registered and unregulated nursing staff, the Resident Assessment Instrument (RAI) coordinator, the manager of the recreation/activation department, the Director of Care and the Administrator in relation to Log # H-000961-14.
The inspector also reviewed clinical records, the home's training records and the home's policy "Restraint Policy" during the course of this inspection.

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

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

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that Personal Assistive Service Devices (PASDs) that had the effect of limiting or inhibiting a resident's freedom of movement and the resident was not able to release the device, was allowed to be included in the plan of care, in accordance with LTCHA 2007, S. O., c. 8, 33(4), in relation to the following: [33(3)]
a) In accordance with LTCHA 2007, S. O., c. 8, 33(4) 1, the use of a PASD that has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able to release themselves can only be included in the resident's plan of care if alternatives to the use of the PASD have been considered, tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine of daily living.
The PASD devices that inhibited the freedom of movement and were noted to be applied to resident #001, resident #004, resident #005 and resident #006 on February 18, 2015, were not allowed to be included in these resident's plans of care. Staff and clinical documentation confirmed that alternatives to the use of these PASD devices that inhibited the resident's freedom of movement were not considered or tried and found to be ineffective before implementing this care intervention for resident #001, resident #004, resident #005 and resident #006. Staff confirmed that the devices used for these residents could not be removed by the residents, were identified as PASD's to assist with positioning and were to be applied while these residents were sitting in chairs.
b) In accordance with LTCHA 2007, S. O., c. 8, 33(4) 4, the use of a PASD that has the effect of limiting or inhibiting a resident's freedom of movement and that resident was not able to release themselves, can only be included in the resident's plan of care if the PASD device 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.
Consents for the use of PASD devices noted to be applied to resident #005 and resident #006 on February 18, 2015 were not allowed to be in the plans of care for these residents. Staff and clinical documentation confirmed that consent for the PASD devices that inhibited the residents freedom of movement were not obtained prior to including this intervention in the plan of care for resident #005 and resident #006. Staff confirmed these devices could not be removed by these residents, were identified as PASD's to assist with positioning and were to be applied while these residents were sitting in chairs. [s. 33. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of the physical functioning and the type and level of assistance required related to activities of daily living, in relation to the following: [26(3)7]
a) Resident #001's plan of care was not based on an interdisciplinary assessment of the assistance the resident required prior to the use of a Personal Assistive Services Device (PASD) that had the effect of limiting or inhibiting the resident's freedom of movement. Resident #001 was noted to be sitting in a specialized chair with a PASD device applied at 1115hrs on February 18, 2015. Staff and clinical documentation confirmed the resident was unable to remove the device and the device was being used as a PASD to assist the resident with positioning while sitting in the chair. Staff and the clinical record confirmed that an interdisciplinary assessment to determine if this PASD was reasonable in light of the resident's physical condition or that this was the least restrictive of such PASDs, in accordance with LTCHA 2007, S. O., c. 8, 33(4) 2, had not been completed.
b) Resident #004's plan of care was not based on an interdisciplinary assessment of the assistance the resident required prior to the use of a Personal Assistive Services Device (PASD) that had the effect of limiting or inhibiting the resident's freedom of movement. Resident #004 was noted to be sitting in a specialized chair with a PASD device applied at 1130hrs on February 18, 2015. Staff and clinical documentation confirmed the resident was unable to remove the device and the device was being used as a PASD to assist the resident with positioning while sitting in the chair. Staff and the clinical record confirmed that an interdisciplinary assessment to determine if this PASD was reasonable in light of the resident's physical condition or that this was the least restrictive of such PASDs, in

accordance with LTCHA 2007, S. O., c. 8, 33(4) 2, had not been completed.
c) Resident #005's plan of care was not based on an interdisciplinary assessment of the assistance the resident required prior to the use of a Personal Assistive Services Device (PASD) that had the effect of limiting or inhibiting the resident's freedom of movement. Resident #005 was noted to be sitting in a specialized chair with a PASD device applied at 1145hrs on February 18, 2015. Staff and clinical documentation confirmed the resident was unable to remove the device and the device was being used as a PASD to assist the resident with positioning while sitting in the chair. Staff and the clinical record confirmed that an interdisciplinary assessment to determine if this PASD was reasonable in light of the resident's physical condition or that this was the least restrictive of such PASDs, in accordance with LTCHA 2007, S. O., c. 8, 33(4) 2, had not been completed.
d) Resident #006's plan of care was not based on an interdisciplinary assessment of the assistance the resident required prior to the use of a Personal Assistive Services Device (PASD) that had the effect of limiting or inhibiting the resident's freedom of movement. Resident #006 was noted to be sitting in a specialized chair with a PASD device applied at 1145hrs on February 18, 2015. Staff and clinical documentation confirmed the resident was unable to remove the device and the device was being used as a PASD to assist the resident with positioning while sitting in the chair. Staff and the clinical record confirmed that an interdisciplinary assessment to determine if this PASD was reasonable in light of the resident's physical condition or that this was the least restrictive of such PASDs, in accordance with LTCHA 2007, S. O., c. 8, 33(4) 2, had not been completed. [s. 26. (3) 7.]

2. The licensee failed to ensure the plan of care was based on, at a minimum, an interdisciplinary assessment of safety risks, in relation to the following: [26(3)19]
a) Resident #001's plan of care was not based on an interdisciplinary assessment of the risk of harm to the resident, prior to a seat belt restraint being included in the plan of care. Staff and clinical documentation confirmed that resident #001 was restrained with the use of a seat belt restraint while sitting in a chair over a nine month period of time in 2014. Staff and the clinical record also confirmed that and an interdisciplinary assessment of the risk to the resident related to this intervention, in accordance with LTCHA 2007, S. O., c. 8 31(2)1, had not been completed.
b) Resident #002's plan of care was not based on an interdisciplinary assessment of risk of harm to the resident, prior to a seat belt restraint being included in the plan of care. On an identified date in February 2015 at 1130hrs resident #002 was noted to be sitting in a wheelchair in the lounge with a front fastening seat belt applied. Staff and the clinical record confirmed that an interdisciplinary assessment of the risk to the resident related to this intervention, in accordance with LTCHA 2007, S. O., c. 8 31(2)1, had not been

completed. [s. 26. (3) 19.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (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 apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

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

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:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that a physical device used to restrain a resident under section 31 of the Act was applied in accordance with the manufacturer's instructions, in relation to the following: [110(1) 1]
a) Staff did not apply a seat belt being used to restrain resident #002 in accordance with

the manufactures instructions. Resident #002 was observed on February 13, 2014 at 1130hrs to be sitting in a specialized chair in the lounge with a front fastening push button type seat belt applied. The seat belt was noted to be applied loosely and there was a 4-5 inch gap between the resident's body and the seat belt. At this time an RPN who attended the resident confirmed that the seat belt was not applied properly and was too loose. Staff and clinical documentation confirmed the seat belt was being used to restrain the resident as an intervention for the management of falls. Manufacturer's instructions provided by the home instructed that when properly adjusted and the belt tightened, it should fit snug so that the user's pelvis is secure.
b) Staff did not apply a seat belt being used to restrain resident #003 in accordance with the manufactures instructions. Resident #003 was observed on February 13, 2014 at 1130hrs to be sitting in a specialized chair in the lounge with a front fastening push button type seat belt applied. The seat belt was noted to be applied loosely and there was a 4-5 inch gap between the resident's body and the seat belt. At this time an RPN who attended the resident confirmed that the seat belt was not applied properly and was too loose. Staff and clinical documentation confirmed the seat belt was being used to restrain the resident as an intervention for the management of falls. Manufacturer's instructions provided by the home instructed that when properly adjusted and the belt tightened, it should fit snug so that the user's pelvis is secure. [s. 110. (1) 1.]

2. The licensee failed to ensure that where a resident is being restrained by a physical device that the resident is released from the physical device and repositioned at least once every two hours, in relation to the following: [110(2) 4]
a) Staff and clinical documentation confirmed that resident #002 was being restrained with the use of a front fastening seat belt that the resident could not remove, when up in the chair as an intervention to manage a risk for falling. The Director of Care and the home's "Restraint Policy" confirmed that Personal Support Workers (PSW) were expected to document the care provided to the resident in the Point of Care (POC) computerized clinical record. Over an eight day period clinical documentation indicated that staff did not release the physical device or repositioned the resident at least once every two hours when staff documented that the following care was provided to the resident:
- Staff documented on February 1, 2015 the resident was repositioned while in the restraint at 1428hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of five hours when the documentation indicated the restraint was removed at 2042hrs.
-Staff documented on February 2, 2015 the resident was repositioned while in the restraint at 1526hrs. Documentation of care provided indicated the restraint was not

removed or the resident repositioned for a period of time in excess of five hours when staff documented the restraint was removed at 2040hrs.
-Staff documented on February 3, 2015 the resident was repositioned while in the restraint at 1002hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of 10 hours when staff documented the resident was repositioned at 2019hrs and the restraint was removed at 2020hrs.
-Staff documented on February 4, 2015 the resident was repositioned while in the restraint at 1331hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of six hours when staff documented the resident was repositioned at 2021hrs.
-Staff documented on February 5, 2015 the resident was repositioned while in the restraint at 1127hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of three hours when staff documented the resident was repositioned at 1426hrs.
-Staff documented on February 6, 2015 the restraint was applied 1423hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of six hours when staff documented the restraint was removed at 2016hrs.
-Staff documented on February 7, 2015 the resident was repositioned while in the restraint at 1349hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of six hours when staff documented the restraint was removed at 2017hrs
b) Staff and clinical documentation confirmed that resident #003 was being restrained with the use of a front fastening seat belt that the resident could not remove, when up in the chair as an intervention to manage a risk for falling. The Director of Care and the home's "Restraint Policy" confirmed that Personal Support Workers (PSW) were expected to document the care provided to the resident in the Point of Care (POC) computerized clinical record. Over an eight day period clinical documentation indicated that staff did not release the physical device or repositioned the resident at least once every two hours when staff documented that the following care was provided to the resident:
- Staff documented on February 1, 2015 the resident was repositioned while in the restraint at 1601hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of five hours when staff documented the restraint was removed at 2129hrs.
- Staff documented on February 2, 2015 the resident was repositioned while in the restraint at 1550hrs. Documentation of care provided indicated the restraint was not

removed or the resident repositioned for a period of time in excess of four hours when staff documented the restraint was removed at 2049hrs.
- Staff documented on February 3, 2015 the resident was repositioned while in the restraint at 1049hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of two hours when staff documented the resident was repositioned at 1342hrs. Documentation of care also indicated that the restraint was not removed and the resident was not repositioned for a period of time in excess of two hours when documentation indicated the resident was repositioned at 1342hrs and then again at 1630hrs. Documentation of care also indicated that the restraint was not removed and the resident was not repositioned for a period of time in excess of five hours when staff documented that the resident was repositioned at 1630hrs and then removed the restraint at 2130hrs.
- Staff documented on February 4, 2015 the resident was repositioned while in the restraint at 1612hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of three hours when staff documented the restraint was removed and the resident was repositioned at 1952hrs.
- Staff documented on February 5, 2015 the resident was repositioned while in the restraint at 1051hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of two hours when staff documented the restraint was removed at 1352hrs. Documentation of care also indicated the restraint was not removed or the resident repositioned for a period of time in excess of five hours when staff documented that the restraint was applied at 1626hrs and removed at 2100hrs.
- Staff documented on February 6, 2015 the resident was repositioned while in the restraint at 1041hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of two hours when staff documented the resident was repositioned at 1339hrs. Documentation of care also indicated the restraint was not removed and the resident repositioned for a period of time in excess of 4 hours when staff documented that the restraint was applied at 1536hrs and the resident was repositioned at 1938hrs.
- Staff documented on February 7, 2015 the resident was repositioned while in the restraint at 1108hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of two hours when staff documented the resident was repositioned at 1349hrs. Documentation of care also indicated the restraint was not removed and the resident repositioned for a period of time in excess of four hours when staff documented the resident was repositioned at 1522hrs and the restraint was removed at 1954hrs.

- Staff documented on February 8, 2015 the resident was repositioned while in the restraint at 1100hrs. Documentation of care provided indicated the restraint was not removed or the resident repositioned for a period of time in excess of two hours when staff documented the resident was repositioned at 1345hrs. Documentation of care also indicated the restraint was not removed and the resident repositioned for a period of time in excess of four hours when staff documented the restraint was applied at 1547hrs and removed at 2032hrs. [s. 110. (2) 4.]

3. The licensee failed to ensure that for every use of a physical device to restrain a resident under section 31 of the act, the alternatives that were considered and why those alternatives were inappropriate were documented, in relation to the following: [110(7) 2]
a) Resident #002 was observed on February 13, 2015 at 1115hrs to be sitting in a specialized chair in the lounge with a front fastening push button seat belt applied. Staff and clinical documentation confirmed that the seat belt was being used to restrain the resident as an intervention to manage a risk of falling and the resident was not able to remove the seat belt. The Director of Care confirmed that an initial restraint assessment was not completed for this restraint and the first assessment for this restraint, identified as a "Quarterly Review for Use of Physical Restraint" completed on November 26, 2014 did not contain documentation to indicate that alternatives to the use of the seat belt restraint were considered.
b) Resident #003 was observed on February 13, 2015 at 1130hrs to be sitting in a specialized chair in the lounge with a front fastening push button seat belt applied. Staff and clinical documentation confirmed that the seat belt was being used to restrain the resident as an intervention to manage a risk of falling and the resident was not able to remove the seat belt. Staff and clinical documentation confirmed that the initial assessment for use of the seat belt completed on April 1, 2014 did not identify what alternatives to the use of the seat belt were considered. [s. 110. (7) 2.]

Additional Required Actions:

CO # - 003, 005 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 and ensuring that where a resident is being restrained by a physical device that the resident is released from the device and repositioned at least once every two hours, to be implemented voluntarily.

WN #4: 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 failed to ensure that a PASD used under section 33 of the Act, was applied by staff in accordance with the manufacturer's instructions, in relation to the following: [111(2)(b)]
a) Staff did not apply a PASD that limited resident #001's freedom of movement in accordance with the manufactures instructions. Resident #001 was observed on February 13, 2014 at 1115hrs to be sitting in a reclined specialized chair in the lounge with a front fastening clip type seat belt applied. The seat belt was noted to be applied loosely and there was a 4-5 inch gap between the resident's body and the seat belt. At this time an RPN who attended the resident confirmed that the seat belt was not applied properly and was too loose. Staff and clinical documentation confirmed the resident was unable to remove the seat belt and that the device was being used as a PASD to assist the resident with positioning. Manufacturer's instructions provided by the home instructed

that when properly adjusted and the belt tightened, it should fit snug so that the user's pelvis is secure.
b) Staff did not apply a PASD that limited resident #004's freedom of movement in accordance with the manufactures instructions. Resident #004 was observed on February 13, 2014 at 1130hrs to be sitting in a specialized chair with a front fastening push button type seat belt applied. The seat belt was noted to be applied loosely and there was a 3-4 inch gap between the resident's body and the seat belt. At this time an RPN who attended the resident confirmed that the seat belt was not applied properly and was too loose. Staff and clinical documentation confirmed the resident was unable to remove the seat belt and that the device was being used as a PASD to assist the resident with positioning. Manufacturer's instructions provided by the home instructed that when properly adjusted and the belt tightened, it should fit snug so that the user's pelvis is secure.
c) Staff did not apply a PASD that limited resident #005's freedom of movement in accordance with the manufactures instructions. Resident #005 was observed on February 13, 2014 at 1145hrs to be sitting in a specialized chair with a front fastening clip type seat belt applied. The seat belt was noted to be applied loosely and there was a 4-5 inch gap between the resident's body and the seat belt. At this time an RPN who attended the resident attend confirmed that the seat belt was not applied properly and was too loose. Staff and clinical documentation confirmed the resident was unable to remove the seat belt and that the device was being used as a PASD to assist the resident with positioning. Manufacturer's instructions provided by the home instructed that when properly adjusted and the belt tightened, it should fit snug so that the user's pelvis is secure.
d) Staff did not apply a PASD that limited resident #006's freedom of movement in accordance with the manufactures instructions. Resident #006 was observed on February 13, 2014 at 1145hrs to be sitting in a specialized chair with a front fastening push button type seat belt applied. The seat belt was noted to be applied loosely and there was a 4-5 inch gap between the resident's body and the seat belt. At this time an RPN who attended the resident confirmed that the seat belt was not applied properly and was too loose. Staff and clinical documentation confirmed the resident was unable to remove the seat belt and that the device was being used as a PASD to assist the resident with positioning. Manufacturer's instructions provided by the home instructed that when properly adjusted and the belt tightened, it should fit snug so that the user's pelvis is secure. [s. 111. (2) (b)]

Additional Required Actions:

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

WN #5: 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 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 area of how to minimize the restraining of residents and, when restraining is necessary, how to do so in accordance with the Act and the regulations, in relation to the following: [76(7) 4]
The Director of Care confirmed that 101 staff provide direct care to residents in the home. Training records for 2014 confirmed that training in the area of how to minimize the restraining of residents and when restraining is necessary, how to do so in accordance with the Act and the regulations was not provided in 2014. [s. 76. (7) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that all staff who provide direct care to resident receive as a condition of continuing to have contact with the resident, training in the area of how to minimize the restraining of residents and, when restraining is necessary, how to do so in accordance with the Act and the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or medication cart that was secured and locked, in relation to the following: [129(1) (a) (ii)]
Staff did not ensure that the medication cart was secured and locked when on February 20, 2015 at 1210hrs an unlocked medication cart was noted to be sitting in the hall outside the dining room on the second floor home area. There were no staff in the hall and staff in the dining room were unable to make visual contact with the unlocked medication cart. [s. 129. (1) (a) (ii)]

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 be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to minimize the restraining of residents was complied with, in relation to the following: [29(1) (b)]
Staff did not comply with directions contained in the home's policy "Restraint Policy", identified as #N-13.10 and reviewed in February 2014.
-The policy directed that the prescribing clinician should ensure that alternatives have been considered. Staff did not comply with this direction when documentation indicated that resident #002 and resident#003 where being restrained by the use of a front fastening seat belt when in the chair as an intervention to manage a risk of falls and alternatives to the use of the seat belt were not considered for either resident #002 or resident #003.
-The policy directed staff to establish resident focused goals including reduction of the severity, duration or elimination of the restraint. Staff did not comply with this direction when the written plan of care for resident #002 indicates the resident last fell in December 2013 and there are no goals or care interventions included in the written plan of care to reduce the severity, duration or the elimination of the front fastening seat belt being used to restrain the resident whenever sitting in a chair. Staff did not comply with this direction when the written plan of care for resident #003 indicated that the resident had not fallen, the seat belt restraint has been in place since April 2014 and there are no goals or care interventions included in the written plan of care to reduce the severity, duration or the elimination of the front fastening seat belt being used to restraint the resident whenever sitting in a chair.
-The policy directed staff to document every hour on the restraint monitoring record and every two hours when the restraint is released, when the resident is repositioned and care plan interventions have been followed. Staff did not comply with this direction when documentation of care provided to resident #002 and resident #003 did not indicate the residents were checked hourly or that the residents were repositioned every two hours during the time the seat belts were being used to restrain these residents.
-The policy directed that there was to be an annual evaluation of the utilization and effectiveness of the policy for minimizing restraining of residents and what changes and improvements were required in order to ensure the use of restraints is in compliance with the LTCHA. Staff did not comply with this direction when the DOC confirmed that an annual review of the utilization and the effectiveness of the home's policy for minimizing the restraining of residents was not completed.
-The policy directed that staff who provide direct care to residents must receive annual training on the restraint policies, procedures and the correct use of the equipment. Staff did not comply with this direction when the DOC confirmed that this training was not provided to all staff that provided direct care to staff in 2014. [s. 29. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed of an outbreak of a reportable disease, in relation to the following: [107(1)5]
The Director of Care (DOC) confirmed that on January 25, 2015 the home was declared to be in Influenza A outbreak, that the outbreak was declared over on February 12, 2015 and that the home did not notify the Ministry of this outbreak until February 17, 2015 when a voice message was left at the Hamilton Service Area Office. [s. 107. (1) 5.]

WN #9: 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 failed to ensure 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 restraining that is necessary is done in accordance with the Act and the regulations, in relation to the following: [113(b)]
The Director of Care confirmed an annual evaluation to determine the effectiveness of the licensee's policy under section 29 of the Act and what changes and improvements were required to minimize restraining and to ensure that when restraint was necessary was done in accordance with the Act and the regulations was not completed. [s. 113. (b)]

Issued on this 11th day of June, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2015_205129_0003
Log No. / Registre no:	H-000961-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 29, 2015
Licensee / Titulaire de permis :	BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED 600 Lake Street, St. Catharines, ON, L2N-4J4
LTC Home / Foyer de SLD :	HEIDEHOF LONG TERM CARE HOME 600 Lake Street, St. Catharines, ON, L2N-4J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ELENA CADDIS

To BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Order / Ordre :

The licensee shall ensure the all of the requirements identified in LTCHA, 2007, S.O., c. 8, s. 33(4), including what alternatives that have been considered, tried where appropriate, but would not be effective to assist the resident with the routine of daily living. The licensee shall also ensure that the proposed Personal Assistive Services Device (PASD) is consented to by the resident or if the resident is incapable, a substitute decision-maker with the authority to give the consent are met prior to the PASD being included in the resident's plan of care.

Grounds / Motifs :

1. Four of four residents who were identified as using a PASD that had the effect of limiting or inhibiting the resident's freedom of movement did not meet the requirements to have the PASD included in their plan of care.

2. PASD devices that inhibited the freedom of movement and were noted to be applied to resident #001, resident #004, resident #005 and resident #006 on February 18, 2015 were not allowed to be included in these resident's plans of care, in accordance with LTCHA 2007, S. O., c. 8, 33(4) 1. Staff and clinical documentation confirmed that alternatives to the use of PASDs that inhibited the resident's freedom of movement were not considered or tried and found to be ineffective before implementing this care intervention for resident #001, resident #004, resident #005 and resident #006. Staff confirmed that the PASD devices that could not be removed by these residents were identified as PASD's to assist with positioning and were to be applied while these residents were sitting in chairs.

3. PASD devices noted to be applied to resident #005 and resident #006 on February 18, 2015 were not allowed to be in the plans of care for these residents, in accordance with LTCHA 2007, S. O., c. 8, 33(4) 4. Staff and clinical documentation confirmed that consenst for the use of a PASD device that inhibited the resident's freedom of movement were not obtained prior to implementing this care intervention for resident #005 and resident #006. Staff confirmed the use of devices that could not be removed by these residents were identified as PASD's to assist with positioning and were to be applied while these residents were sitting in chairs. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee is to prepare, submit and implement a plan to ensure that interdisciplinary assessments are completed for any resident who is being considered for the use of a restraint or a PASD that has the effect of limiting or inhibiting the resident's freedom of movement. The plan is to include, but is not limited to:
1. The development and implementation of an assessment protocol to determine that residents who are being considered for the use of a restraint have their care needs assessed to clearly identify the specific risk the resident would suffer if the restraint was not used, that the proposed method of restraining is reasonable, in light of the resident's physical and mental condition and that the proposed device is the least restrictive of such reasonable methods.
2. The development and implementation of an assessment protocol to ensure that residents who are being considered for the use of a PASD that has the effect of limiting or inhibiting the resident's freedom of movement have their care needs assessed to determine if the PASD is reasonable in light of the resident's physical condition and that the PASD is the least restrictive of such PASDs.
3. The development and implementation of a schedule for staff training in relation to the above mentioned protocols.
4. The development and implementation of schedule for the application of the assessment protocol for all residents who are currently using a restraint or a PASD that limits or inhibits the resident's freedom of movement.
5. The development and implementation of a method and schedule of ongoing monitoring of staff's performance in implementing the above mentioned assessment protocols.
The plan is to be submitted to Phyllis Hiltz-Bontje by e-mail at Phyllis.Hiltzbontje@Ontario.ca on or before May 13, 2015.

Grounds / Motifs :

1. Previously identified non-compliant on May 6, 2011as a VPC (26(3)10) and on May 6, 2011 as a VPC (26(3)18).

2. The plans of care for two of two residents who were identified as using restraints were not based on, at a minimum, an interdisciplinary assessment of the safety risks to these residents. [26(3)19]
a) Resident #001's plan of care was not based on an interdisciplinary assessment of the risk of harm to the resident, prior to a restraint being included in the plan of care. Staff and clinical documentation confirmed that resident #001

was restrained with the use of a seat belt restraint while sitting in a chair over a nine month period of time in 2014. Staff and the clinical record also confirmed that an interdisciplinary assessment of the risk to the resident related to this intervention, in accordance with LTCHA 2007, S. O., c. 8 31(2)1, had not been completed.

b) Resident #002's plan of care was not based on an interdisciplinary assessment of risk of harm to the resident, prior to a restraint being included in the plan of care. On February 18, 2015 at 1130hrs resident #002 was noted to be sitting in a wheelchair in the lounge with a front fastening seat belt applied. Staff and the clinical record confirmed that and an interdisciplinary assessment of the risk to the resident related to this intervention, in accordance with LTCHA 2007, S. O., c. 8 31(2)1, had not been completed.

3. The plans of care for four of four residents who were identified as using a PASD that had the effect of limiting or inhibiting the resident's freedom of movement were not based on at a minimum, an interdisciplinary assessment of the physical functioning and the type and level of assistance required related to activities of daily living. [26(3)7]
a) Resident #001's plan of care was not based on an interdisciplinary assessment of the assistance the resident required prior to the use of a Personal Assistive Services Device (PASD) that had the effect of limiting or inhibiting the resident's freedom of movement. Resident #001 was noted to be sitting in a specialized chair with a PASD device applied at 1115hrs on February 18, 2015. Staff and clinical documentation confirmed the resident was unable to remove the device and the device was being used as a PASD to assist the resident with positioning while sitting in the chair. Staff and the clinical record confirmed that an interdisciplinary assessment to determine if this PASD was reasonable in light of the resident's physical condition or that this was the least restrictive of such PASDs, in accordance with LTCHA 2007, S. O., c. 8, 33(4) 2, had not been completed.

b) Resident #004's plan of care was not based on an interdisciplinary assessment of the assistance the resident required prior to the use of a Personal Assistive Services Device (PASD) that had the effect of limiting or inhibiting the resident's freedom of movement. Resident #004 was noted to be sitting in a specialized chair with a PASD device applied at 1130hrs on February 18, 2015. Staff and clinical documentation confirmed the resident was unable to remove the device and the device was being used as a PASD to assist the resident with

positioning while sitting in the chair. Staff and the clinical record confirmed that an interdisciplinary assessment to determine if this PASD was reasonable in light of the resident's physical condition or that this was the least restrictive of such PASDs, in accordance with LTCHA 2007, S. O., c. 8, 33(4) 2, had not been completed.

c) Resident #005's plan of care was not based on an interdisciplinary assessment of the assistance the resident required prior to the use of a Personal Assistive Services Device (PASD) that had the effect of limiting or inhibiting the resident's freedom of movement. Resident #005 was noted to be sitting in a specialized chair with a PASD device applied at 1145hrs on February 18, 2015. Staff and clinical documentation confirmed the resident was unable to remove the device and the device was being used as a PASD to assist the resident with positioning while sitting in the chair. Staff and the clinical record confirmed that an interdisciplinary assessment to determine if this PASD was reasonable in light of the resident's physical condition or that this was the least restrictive of such PASDs, in accordance with LTCHA 2007, S. O., c. 8, 33(4) 2, had not been completed.

d) Resident #006's plan of care was not based on an interdisciplinary assessment of the assistance the resident required prior to the use of a Personal Assistive Services Device (PASD) that had the effect of limiting or inhibiting the resident's freedom of movement. Resident #006 was noted to be sitting in a specialized chair with a PASD device applied at 1145hrs on February 18, 2015. Staff and clinical documentation confirmed the resident was unable to remove the device and the device was being used as a PASD to assist the resident with positioning while sitting in the chair. Staff and the clinical record confirmed that an interdisciplinary assessment to determine if this PASD was reasonable in light of the resident's physical condition or that this was the least restrictive of such PASDs, in accordance with LTCHA 2007, S. O., c. 8, 33(4) 2, had not been completed.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (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 apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure every physical device used to restrain a resident is applied accordance with any manufacturer's instructions. The plan is to include but is not limited to:
1. The immediate development and implementation of a system for monitoring the application of all front fastening seat belts that are being used by residents in the home.
2. The development and implementation of a training program for all staff that provide care to residents related to the manufacturer's instructions for the application of seat belts.
3. The development of a method and schedule for ongoing monitoring of staff's performance in the correct application of front fastening seat belt.
The plan is to be submitted to Phyllis Hiltz-Bontje by e-mail at Phyllis.Hiltzbontje@Ontario.ca on or before May 13, 2015.

Grounds / Motifs :

1. Previously identified non-compliant under LTCHA, 2007, S.O., c. 8, s, 31(3) (a) on December 6, 2013 as a CO and in accordance with this regulation on February 13, 2014 as a CO.

2. Two of two residents who were noted to be restrained did not have the device applied according to manufacturer's instructions.

3. Staff did not apply a seat belt being used to restrain resident #002 in accordance with the manufactures instructions. Resident #002 was observed on February 13, 2014 at 1130hrs to be sitting in a specialized chair in the lounge with a front fastening push button type seat belt applied. The seat belt was noted to be applied loosely and there was a 4-5 inch gap between the resident's body and the seat belt. At this time an RPN who attended the resident confirmed that the seat belt was not applied properly and was too loose. Staff and clinical documentation confirmed the seat belt was being used to restrain the resident as an intervention for the management of falls. Manufacturer's instructions provided by the home instructed that when properly adjusted and the belt tightened, it should fit snug so that the user's pelvis is secure.

4. Staff did not apply a seat belt being used to restrain resident #003 in accordance with the manufactures instructions. Resident #003 was observed on February 13, 2014 at 1130hrs to be sitting in a specialized chair in the lounge with a front fastening push button type seat belt applied. The seat belt was noted to be applied loosely and there was a 4-5 inch gap between the resident's body and the seat belt. At this time an RPN who attended the resident confirmed that the seat belt was not applied properly and was too loose. Staff and clinical documentation confirmed the seat belt was being used to restrain the resident as an intervention for the management of falls. Manufacturer's instructions provided by the home instructed that when properly adjusted and the belt tightened, it should fit snug so that the user's pelvis is secure. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 111. (2) Every licensee shall 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. O. Reg. 79/10, s. 111. (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all devices being used as PASD's that have the effect of limiting or inhibiting resident's freedom of movement are applied in accordance with any manufactures instructions. The plan is to include, but is not limited to:
1. The immediate development and implementation of a system for monitoring the application of all front fastening seat belt PASDs that are being used by residents in the home.
2. The development and implementation of a training program for all staff that provide care to residents related to the manufacturer's instructions for the application of seat belt PASDs.
3. The development of a method and schedule for ongoing monitoring of staff's performance in the correct application of front fastening seat belt PASDs.
The plan is to be submitted to Phyllis Hiltz-Bontje by e-mail at Phyllis.Hiltzbontje@Ontario.ca on or before May 13, 2015

Grounds / Motifs :

1. Four of four residents who were noted to have a front fastening seat belt PASD applied under section 33 of the Act, did not have the device applied according to manufacturer's instructions.

2. Staff did not apply a PASD that limited resident #001's freedom of movement in accordance with the manufactures instructions. Resident #001 was observed on February 13, 2014 at 1115hrs to be sitting in a reclined specialized chair in the lounge with a PASD device applied. The device was noted to be applied

loosely and there was a 4-5 inch gap between the resident's body and the device. At this time an RPN who attended the resident confirmed that the device was not applied properly and was too loose. Staff and clinical documentation confirmed the resident was unable to remove the device and that the device was being used as a PASD to assist the resident with positioning. Manufacturer's instructions provided by the home instructed that when properly adjusted and the device tightened, it should fit snug so that the user's pelvis is secure.

3. Staff did not apply a PASD that limited resident #004's freedom of movement in accordance with the manufactures instructions. Resident #004 was observed on February 13, 2014 at 1130hrs to be sitting in a specialized chair in the lounge with a PASD device applied. The device was noted to be applied loosely and there was a 3-4 inch gap between the resident's body and the device. At this time an RPN who attended the resident confirmed that the device was not applied properly and was too loose. Staff and clinical documentation confirmed the resident was unable to remove the device and that the device was being used as a PASD to assist the resident with positioning. Manufacturer's instructions provided by the home instructed that when properly adjusted and the device tightened, it should fit snug so that the user's pelvis is secure.

4. Staff did not apply a PASD that limited resident #005's freedom of movement in accordance with the manufactures instructions. Resident #005 was observed on February 13, 2014 at 1145hrs to be sitting in a specialized chair with a PASD device applied. The device was noted to be applied loosely and there was a 4-5 inch gap between the resident's body and the device. At this time an RPN who attended the resident confirmed that the device was not applied properly and was too loose. Staff and clinical documentation confirmed the resident was unable to remove the device and that the device was being used as a PASD to assist the resident with positioning. Manufacturer's instructions provided by the home instructed that when properly adjusted and the device tightened, it should fit snug so that the user's pelvis is secure.

5. Staff did not apply a PASD that limited resident #006's freedom of movement in accordance with the manufactures instructions. Resident #006 was observed on February 13, 2014 at 1145hrs to be sitting in a specialized chair in the lounge with a PASD device applied. The seat device was noted to be applied loosely and there was a 4-5 inch gap between the resident's body and the device. At this time an RPN who attended the resident confirmed that the device was not applied properly and was too loose. Staff and clinical documentation confirmed the resident was unable to remove the device and that the device was being used as a PASD to assist the resident with positioning. Manufacturer's instructions provided by the home instructed that when properly adjusted and

the deivce tightened, it should fit snug so that the user's pelvis is secure. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

Order # / Ordre no : 005

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

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 shall prepare, submit and implement a plan to ensure that when a resident is considered for the use of restraints, what alternatives to the device were considered and why those alternatives were inappropriate is documented.
The plan is to include, but is not limited to:
1. The development and implementation of a tool for the documentation of alternatives that have been considered, tried and why those alternatives where considered to be inappropriate to meet the needs of the resident.
2. The development and implantation of a process to ensure that devices and strategies that could be considered alternatives to the use of restraints are readily available to staff assessing the needs of residents.
3. The development and implementation of a training program related to the types of restraints used in the home, the devices available in the home that would be considered alternatives to restraints and the difference between a restraint, a device that is considered least restrictive device and an alternative to restraints as well as the tool staff are to use related to the assessment of alternatives to restraints.
The plan is to be submitted to Phyllis Hiltz-Bontje by e-mail at Phyllis.Hiltzbontje@Ontario.ca on or before May 13, 2015

Grounds / Motifs :

1. Previously identified non-compliant on May 6, 2011 as a VPC.

2. Staff did not consider the use of alternatives to restraints for two of two residents who were noted to be restrained by the use of a physical device.

3. Resident #002 was observed on February 13, 2015 at 1115hrs to be sitting in a specialized chair in the lounge with a front fastening push button seat belt applied. Staff and clinical documentation confirmed that the seat belt was being used to restrain the resident as an intervention to manage a risk of falling and the resident was not able to remove the seat belt. The Director of Care confirmed that an initial restraint assessment was not completed for this restraint and the first assessment for this restraint, identified as a "Quarterly Review for Use of Physical Restraint" completed on November 26, 2014 did not contain documentation to indicate that alternatives to the use of the seat belt restraint were considered.

4. Resident #003 was observed on February 13, 2015 at 1130hrs to be sitting in a specialized chair in the lounge with a front fastening push button seat belt applied. Staff and clinical documentation confirmed that the seat belt was being used to restrain the resident as an intervention to manage a risk of falling and the resident was not able to remove the seat belt. Staff and clinical documentation confirmed that the initial assessment for use of the seat belt completed on April 1, 2014 did not identify what alternatives to the use of the seat belt were considered. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 29th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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