Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Feb 17, 2017	2017_357648_0002	031805-16	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Aurora Long Term Care Residence
32 MILL STREET AURORA ON L4G 2R9

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

JOVAIRIA AWAN (648), JANET GROUX (606), ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 19, 20, 23, 24, 25, 26, and 27, 2017.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration , infection control prevention and practices, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council, Family Council questionnaire, minutes of relevant committee meetings, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the administrator, the director of care (DOC), assistant director of care (ADOC), assistant food services manager (AFSM), programs services manager, social worker, registered nurses (RN), registered practical nurses (RPN), personal support worker(s) (PSW) residents, and substitute decision makers (SDM).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident.

Resident #003 was identified for the use of bed rails by stage one observations during the Resident Quality Inspection (RQI).

Review of resident #003's clinical records identified conflicting interventions in two separate areas of the plan of care under different focuses. One of the interventions identified the use of the bed rails as a restraint, while the second intervention identified the bed rails as a Personal Assistance Service Device (PASD).

Review of resident #003's clinical records documented the use of bed rails as a restraint, to prevent the resident from falls and self transfers, initiated on an identified date. Review of the physician's orders for resident #003 over a 12 month period identified the use of bed rails as restraints in the quarterly medication reviews completed.

Interview with resident #003's SDM identified resident #003 was unable to move independently and the bed rails were used to prevent the resident from rolling out of bed.

Interview with PSW #103 revealed resident #003 used the bed rails for repositioning in bed.

Interview with PSW #112 revealed bed rails were used for resident #003 to prevent the resident from falls.

Interview with RN #117 identified the duties of the registered staff included reviewing and updating a resident's plan of care each time there is a change in their condition or treatment interventions. The RN confirmed bed rails were used as a restraint for resident #003. Review of the care plan with RN #117 during the staff interview identified the use of bed rails as a PASD and as a restraint. The RN confirmed this was a discrepancy in the plan of care and it did not provide clear direction to staff regarding the use of bed rails for resident #003.

Interview with the DOC and ADOC acknowledged the direction provided in the plan of care did not set out clear directions to staff regarding the use of the bed rails for resident #003 as a PASD or as a restraint as both were documented in the same plan of care. [s. 6. (1) (c)]

2. Resident #006 was identified in stage one of the RQI inspection to have a worsening skin integrity according to the most recent assessment relative to the previous MDS assessment. Review of resident #006's MDS Admission Assessment, identified the resident had two areas of impaired skin integrity.

Review of the home's policy entitled Recording of Daily Care (LTC-CA-WQ-200-01-11, effective July 2015) indicated care staff are responsible to be aware of care needs of the residents they are providing care for and Care needs can be reviewed either on a paper Kardex or through the Point of Care (POC) application by clicking on the Kardex button within the resident profile.

Review of resident #006's written plan of care did not identify that the resident had the skin impairments as noted above until a later identified date when one of the areas of altered skin integrity worsened.

Review of the resident's Kardex from an identified period between 2016 to 2017, did not identify that resident #006 had the second worsening area of altered skin integrity.

Interviews with PSW #114 and #121 revealed they were not aware that resident #006 had the second area of identified altered skin integrity since they started providing care to him/her in 2016 and confirmed they did not provide any interventions with regards to his/her skin impairment.

Interview with the DOC confirmed the above staff were not aware of resident #006's area of altered skin integrity because the evening night staff were responsible to provide care such as dressing and showering the resident and not the PSWs on the day shift. The DOC stated he/she will update the Kardex and will speak to the PSWs so all staff on all the shifts are made aware about resident #006's care regarding the second identified area of altered skin integrity. [s. 6. (8)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Resident #006 was identified in stage one of the RQI inspection to have worsening skin integrity according to the most recent assessment dated, relative to the previous MDS assessment.

Review of resident #006's TAR over a three month period in 2016 directed staff to monitor the resident's altered skin integrity multiple times a day.

Review of resident #006's TARs revealed 10 times staff failed to document care provided between the identified three month period in 2016.

Interviews with RN #105, RPN #116, and the DOC confirmed the home's practice is to sign off the TARs after being provided. [s. 6. (9)]

4. During stage one of the RQI inspection, resident #007 was identified to have worsening skin integrity according to the most recent MDS assessment, relative to the previous MDS assessment.

Review of the home's policy entitled Recording of Daily Care (LTC-CA-WQ-200-01-11, effective July 2015), stated care staff are responsible for delivering the care as assessed and documenting care provided prior to leaving the home area at the end of their shift.

Review of resident #007's Care Records for two identified months in 2016, and one identified month in 2017 directed staff to turn and reposition the resident every two hours. Further review of the TARs revealed 42 times staff failed to document care provided over the two month period in 2016 and the one month period in 2017.

Interviews with PSWs #115, #113, RPN #116, and RN #105 revealed staff are to document care provided after it has been provided and must be done before the end of their shift.

Interview with the DOC confirmed it is the home's expectation for all staff to document care provided to a resident and had not been completed resident #007. [s. 6. (9) 1.]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care was revised because care sets out in the plan of care has not been effective, different approaches are considered in the revision of the plan of care.

Resident #006 was identified in stage one of the RQI inspection to have worsening skin integrity according to the most recent assessment, relative to the previous MDS assessment.

Review of resident #006's MDS Admission Assessment, indicated the resident had identified areas of altered skin integrity. One of these areas of altered skin integrity worsened, and was assessed and identified on a the SKIN - Weekly Other Skin Alteration, on an identified date in 2016.

Review of the related TAR directed the registered staff to ensure interventions were applied for the resident's skin care management.

Interview with RPN #116 revealed one of the interventions to treat resident #006's was to apply protection appliances to the resident and stated the resident was refusing the intervention when the treatment was initiated and therefore was not applied.

Interview with the DOC stated that the intervention was ordered for resident #006 but

was not being applied because the resident had refused this intervention. intervention.

The home failed to ensure that effective, different approaches were considered for resident #006 when the care set out in the plan of care had not been effective. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the written plan of care for a resident sets out clear directions to staff and others
who provide direct care to the resident.
- to ensure that the staff and others who provide direct care to a resident are kept aware of
the contents of the resident's plan of care and have convenient and immediate access to it.
- to ensure that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

Observations during the initial home tour on January 19, 2016, at 1005 hrs identified a room labelled BATH on the second floor in the east building hallway. The inspector noted the room door propped open with three lifts and other miscellaneous items such as continence products and slings with no staff in the near vicinity.

Subsequent observations made on January 20, 2017, at 1035 hrs, January 24, 2017, at 1254 hrs, January 25, 2017, at 1138 hrs, and on January 26, 2017, at 0928 hrs identified the same room with no staff in the near vicinity. The door of the room was observed propped open and multiple lifts, slings, and continence items were noted in plain view.

Interview with PSW #107 January 20, 2017 at 1035 hrs reported the identified room labelled BATH was to remain closed when not in use as it was a non resident area. PSW #107 reported the room had been open since 0700 hrs that day.

On January 19, 2017, at 0958 hrs during the initial home tour and January 20, 2017, at 1040 hrs, on home area G2, on the second floor west building, a room marked "Resident Storage", was observed open with items such as furniture, fans, and other equipment items. There was no staff observed around the area during the time of this observation.

Interview with PSW #106 on January 20, 2017, at 1040 hrs reported the resident storage room considered the Resident Storage room a non residential area and should not be accessible to the residents. The PSW confirmed the Resident Storage area if left open and unsupervised was a safety hazard and poses a risk for injury to wandering residents.

Interview and observations with the home's Administrator for the room labelled BATH on the second floor east building demonstrated the room had a functional lock.

The home failed to ensure all doors leading to non-residential areas were kept closed and locked when they are not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance To ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown such as a pressure ulcers was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #007 was identified from stage one of the RQI to have a worsening skin integrity according to the most recent MDS assessment, relative to the previous MDS assessment.

Review of resident #007's Point Click Care Initial Skin and Wound Assessment on an identified date in 2016, and admission progress notes on an identified date in 2016, indicated the resident presented with an identified area of altered skin integrity.. Further review of resident #007's weekly skin and wound assessment indicated missing weekly skin assessments for 13 identified assessments over a period of four months in 2016.

Interview with resident #007 and RN #105 revealed the resident was admitted to the home with an identified area of altered skin integrity.

Interviews with RN #105 and RPN # and the DOC revealed the home's practice is to complete the weekly skin and wound assessment in PCC for resident with resident's identified with altered skin integrity.
The licensee has failed to ensure that resident #007 was reassessed for his/her area of identified altered skin integrity at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers received immediate treatment and interventions to promote healing, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy, or system is implemented in accordance with applicable requirements under the Act and was complied with.

During stage one of the RQI, resident #005 was identified for the use of bed rails.

Review of resident #005's clinical records, identified the use of bed rails as a restraint to prevent falls. According to the plan of care the bed rails were initiated on an identified date in 2015 and discontinued on an identified date in 2017.

Record review of the homes policy entitled, Physical Restraint (LTC-CA-WQ-200-07-19, revised July 2016), in the Clinical and Resident Care manual identified the use of a physical restraint for a resident required:
- Evaluation by the DOC or designate through the completion of the Monthly Restraint Evaluation workbook;
- Quarterly evaluation and completion of the restraint assessment.

Interview with RN #105 reported resident #005 used bed rails as a restraint. The RN stated residents using restraints were to be assessed on a quarterly basis by the registered staff, and stated consent for restraints was to be obtained annually. RN #105 was unable to demonstrate resident #005 had been assessed on a quarterly basis for the use of his/her restraint.

Interview with the DOC revealed residents that use bed rails as a restraint were to be evaluated through the completion of quarterly assessments and the monthly restraint evaluation. The DOC was unable to demonstrate quarterly assessments and monthly

restraint evaluation for the use of side rails as a restraint for resident #005 had been completed and obtained.

The home failed to ensure the Physical Restraint policy was complied with. [s. 8. (1) (b)]

2. Resident #003 was identified using full length bed rails on both sides of his/her bed during stage one observations during the RQI.

Review of resident #003's clinical records documented the use of bed rails as a restraint, to prevent the resident from falls and self transfers, initiated on an identified date in 2015. Review of the physician's orders for resident #003 over a period of 12 months spanning 2016 through 2017 identified the use of bed rails as restraints in the quarterly medication reviews.

Record review of the homes policy entitled Physical Restraint (LTC-CA-WQ-200-07-19, revised July 2016), in the Clinical and Resident Care manual identified the use of a physical restraint for a resident required:
- Evaluation by the DOC or designate through the completion of the Monthly Restraint Evaluation workbook;
- Quarterly evaluation and completion of the restraint assessment.

Interview with RN #117 confirmed bed rails were used as a restraint for resident #003. The RN stated residents using restraints were to be assessed on a quarterly basis by the registered staff, and stated and acknowledged resident #003 had not been assessed on a quarterly basis for the use of his/her restraint .

Interview with the DOC revealed residents using bed rails as a restraint were to be evaluated through the completion of quarterly assessments and the monthly restraint evaluation. The DOC was unable to demonstrate quarterly assessments or monthly restraint evaluations for the year of 2016 had been routinely completed for the use of side rails as a restraint for resident #003.

The home failed to ensure the Physical Restraint policy put in place was complied with. [s. 8. (1) (b)]

3. During stage one of the RQI, resident #005 was identified for the use of bed rails.

Review of residents# 005 clinical records identified the use of bed rails as a restraint to

prevent falls. The last updated order for the use of bed rails for resident #005 indicated they were initiated on an identified date in 2015 and discontinued on an identified date in 2017.

Review of the homes Policy titled Physical Restraint (LTC-CA-WQ-200-07-19, revised July 2016), in the Clinical and Resident Care manual identified the use of a physical restraint for a resident required:
- Evaluation by the DOC or designate through the completion of the Monthly Restraint Evaluation workbook;
- Quarterly evaluation and completion of the restraint assessment.

Interview with RN #105 reported resident #005 used bed rails as a restraint. RN #105 stated residents using restraints were to be assessed on a quarterly basis by registered staff. RN #105 was unable to demonstrate resident #005 had been assessed on a quarterly basis for the use of his/her documented restraint.

Interview with the DOC revealed residents using bed rails as a restraint were to be evaluated through the completion of quarterly assessments and the monthly restraint evaluation. The DOC identified the homes process that consent for the use of restraints was required annually. The DOC was unable to demonstrate quarterly assessments and monthly restraint evaluation was undertaken for the use of side rails as a restraint for resident #005.

The home failed to ensure the Physical Restraint policy was complied with. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items were offered and available at each meal.

Review of resident #002's MDS supplement progress note indicated the RD had completed a nutrition assessment for the resident on an identified date in 2016. The assessment revealed a change in resident #002's nutrition status since admission. A nutrition intervention was planned for resident #002 to address the change by the RD. Review of the diet roster and care plan identified the intervention had been documented for resident #002 as per the RD's written recommendation.

Record review of the resident #002's clinical records identified the resident did not receive the intervention on twenty two of thirty instances over a one month period.

Review of the home's policy Dietary Referral in the Clinical section manual (LTC-CA-WQ-300-05-02, revised January 2015) stated that upon identifying a nutrition need by any member of the health care team, the health professional will complete a Dietary Referral progress note, supplying all relevant information.

Interview with PSW #111 identified that all staff are to document the provision and consumption of individualized menu items for residents on their assignment in the POC. PSW #111 revealed he/she was aware of the intervention directing him/her to the nutrition intervention to resident #002. PSW #111 reported he/she had never provided the intervention for resident #002 as it was not being sent up from the kitchen to the floor and therefore, was documented as not applicable in resident #002's POC. PSW #111 stated in such instances, the dietary aide is to be informed of the missing item, but had reported it only to the RPN #122s on a date he/she could not recall. PSW #111 confirmed the resident had not received the intervention at suppertime since the report to the RPN #122

RPN #122 stated he/she communicated with the kitchen using a dietary referral or direct verbal communication when items were not available for a resident. RPN #122 revealed he/she was aware that resident #002 was not receiving the intervention. However, RPN #122 was unable to confirm that he/she had communicated this concern to the kitchen upon becoming aware of it, and confirmed that resident #002 was not currently receiving the intervention as per the care plan.

Interview with the AFSM #118 revealed residents in the home with individualized interventions as recommended by the RD are to receive the items prepared as labelled nourishments. AFSM #118 reported the PSWs and registered staff are expected to use the home's process for communicating with the kitchen by sending dietary referrals when

an item was not available during the evening or night shift.

The AFSM was unaware that resident #002 had not been receiving the intervention as documented. The AFSM was unable to demonstrate that PSW or registered staff had used the home's communication process to identify the missing labelled nourishment for resident #002 to the kitchen. The AFSM acknowledged the resident had not been receiving the intervention as indicated in the plan of care. [s. 71. (4)]

WN #6: 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 an analysis of the restraining of residents by use of a physical device under section 31 of the Act was undertaken on a monthly basis.

During stage one of the RQI, resident #005 was identified for the use of bed rails.

Review of resident #005's clinical records identified the use of bed rails as a restraint to prevent falls. The bed rails were initiated on an identified date in 2015 and discontinued on an identified date in 2017.

Review of resident #005's MAR identified the use of the bed rails as a restraint. Quarterly medication reviews in resident #005's physical chart identified the use of the bed rails as a restraint for the year of 2016.

Review of the home's policy titled Physical Restraint (LTC-CA-WQ-200-07-19, revised July 2016), in the Clinical and Resident Care manual identified the use of a physical restraint for a resident was to be evaluated by the DOC or designate through the completion of the Monthly Restraint Evaluation workbook. Review of the Monthly Restraint Analysis workbook for three different months in 2016 did not identify resident #005 had been captured in the monthly restraint evaluation.

Interview with the DOC and ADOC revealed the home's process included residents using restraints were to be included in the monthly restraint evaluation and acknowledged resident #005 had not been captured in the monthly restraint evaluation because an analysis of the restraining of resident #005 by use of a physical device was not undertaken on a monthly basis. [s. 113. (a)]

2. Resident #003 was identified using full length bed rails on both sides of his/her bed during stage one observations during the RQI.

Review of resident #003’s clinical records documented the use of bed rails as a restraint, to prevent the resident from falls and self transfers, initiated on an identified date in 2015. Review of the physician's orders for resident #003 over a 12 month period identified the use of bed rails as restraints in the quarterly medication reviews.

Review of the homes Policy titled Physical Restraint (LTC-CA-WQ-200-07-19, last revised July 2016) in the Clinical and Resident Care manual identified the use of a physical restraint for a resident was to be evaluated by the DOC or designate through the compilation of the Monthly Restraint Evaluation workbook. Review of the Monthly Restraint Analysis workbook for months spanning three different months in 2016 did not identify resident #005 had been captured in the Monthly restraint evaluation.

Interview with the DOC and ADOC revealed the home's process included that residents using restraints were to be included in the monthly restraint evaluation and

acknowledged resident #003 had not been captured in the monthly restraint evaluation because an analysis of the restraining of resident #003 by use of a physical device was not undertaken on a monthly basis. [s. 113. (a)]

Issued on this 22nd day of February, 2017

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

Original report signed by the inspector.