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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 9, 2014	2014_215123_0008	H-000513-13,H-000106-14	Complaint

Licensee/Titulaire de permis

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive, Georgetown, ON, L7G-2B8

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

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive, Georgetown, ON, L7G-2B8

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

MELODY GRAY (123)

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): July 3, 4, 8, 9 & 10, 2014

During the course of the inspection, the inspector(s) spoke with residents; the home's management team: including the Administrator, the Director of Care (DOC); the Resident Assessment Instrument Coordinator (RAI Coordinator); registered staff members and Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) reviewed the home's records including policies and procedures, reviewed residents' records, observed equipment and supplies, observed residents and observed staff resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Reporting and Complaints
Sufficient Staffing
Training and Orientation

Findings of Non-Compliance were found during this inspection.

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 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 where the Act or this Regulation requires the

licensee 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, is in compliance with and is implemented in accordance with all applicable requirements under the Act; and is complied with as evidenced by:

A. The home's policy and procedure "Concerns, Issues and Complaints: Process for Obtaining Information, Raising Concerns, Lodging Complaints or Recommending Changes #4.2.10" was reviewed and it included: "Staff information and education sessions will be conducted during orientation and annually thereafter to assist staff with addressing questions and responding to complaints. Every written or verbal complaint made to a staff member concerning the care of a resident or operation of the home is dealt with as follows: A written response must be provided to the person making the complaint within 10 business days of the receipt of the complaint. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgment of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complaint can reasonably expect a resolution, and a follow-up response shall be provided as soon as possible in the circumstances. The Administrator shall ensure that all suggestions, complaints and concerns are documented and a record maintained within the home that includes: The type of action taken to resolve the complaint, including date of action, time frames for actions to be taken and any follow-up action required; The final resolution, if any; Every date on which any response was provided to the complainant and a description of the response and Any response made in turn by the complainant. The Administrator shall ensure that written complaints are reported to the Ministry of Health and Long-Term Care (MOHLTC) within ten (10) business days of receiving the complaint. The Administrator shall submit a copy of the complaint along with a written report documenting the response the home made to the complainant."

i) The Director of Care (DOC) was interviewed and reported that in 2013 the home did not provide annual mandatory staff education including education to assist staff with addressing questions and responding to complaints as per the policies and procedures. The home decided that for 2014 they will be using an external service provider to deliver mandatory staff education which has not yet occurred.

ii) A letter of complaint received in June, 2014 by the home from a family member and or Power of Attorney (POA) expressing concerns about the care of an identified resident #002 was reviewed. The letter also indicated that the home should let the

complainant know if there was a form they needed to fill out, in order to access the information and requested that the home respond within 10 business days, with a date and time that the complainant could visit the home to get the information.
A second complaint letter received by the home in July, 2014 from the POA of resident #002 which included another request for a response to their concerns to be made in writing outlining what action the home will be taking in response to their letter was reviewed.

iii) The home's Complaint Log and Response 2014 was reviewed and it was noted that in June, 2014 a complaint letter was received from the family member of resident #002. The area on the form under the response column was blank. There was no information entered in the area provided related to the home's response to the letter.

iv) The DOC confirmed that the home did not provide a written response to the complaint letters as per the home's policies and procedures and also reported that they investigated the issues and left telephone voicemail messages for the complainant in July, 2014.

v) The home did not follow their policies and procedures related to written complaints as it failed to provide annual staff education related to addressing questions and responding to complaints as per policies and procedures. The home did not provide the complainant a written response within ten business days of the receipt of the complaint as per the policies and procedures. The home did not document the following: The type of action taken to resolve the complaint, including date of action, time frames for actions to be taken and any follow-up action required; The final resolution, if any; Every date on which any response was provided to the complainant and a description of the response, and any response made in turn by the complainant as per the policies and procedures of the home. The home did not report the two written complaints to the MOHLTC as per the policies and procedures of the home.

B. The home's policy "Resident Rights and Safety: Restraints # 4.1.3." was reviewed. It indicated that: "The staff were to be offered annual education on the minimal restraint program; the Registered Nursing staff members are responsible to complete a trial of interventions to address the safety risk to residents or potential risks to other residents and document all interventions attempted and results of those

interventions; the Registered Nursing staff members are to complete a Monthly Restraint Assessment to determine the ongoing need for the restraint and to determine the least restrictive restraining device to be used or to determine the need to discontinue the restraint and that the Registered staff are to ensure that only restraints ordered by the physician are used."
The policy also indicated that: "The interdisciplinary team will review the ongoing need for the restraint monthly and whenever there is a change in the resident's condition; the resident care plan is reviewed and updated to reflect current interventions and new strategies monthly and whenever there is a change in the resident's condition."

i) The DOC was interviewed and reported that the annual staff education related to restraints was not offered to the staff during 2013.

ii) The Nurse in Charge, Resident Assessment Instrument Coordinator (RAI Coordinator) and the DOC were asked to produce documentation related to the Registered Nursing staff documentation of trialed interventions attempted and the results of those interventions related to the restraints of identified residents #002 through #008. The home was also requested to produce documentation of Monthly Restraint Assessments for identified residents #002 through #008.
The requested documentation of the Registered Nursing staff documentation of trialed interventions and results of those interventions and Monthly Restraint Assessments for residents #002 through #008 were not provided by the home.

iii) The DOC was interviewed and they confirmed that the home's interdisciplinary team did not perform monthly reviews of the ongoing need for the use of physical restraints for residents #002 through #008 as per the home's policies and procedures.

iv) The home did not ensure that the Registered Nursing staff members completed trials of interventions to address the safety risks of residents or potential risks to other residents and documented all interventions attempted an results of those interventions for residents #002 through #008 as per the home's policies and procedures. The home did not follow the policies and procedures related to Registered Nursing Staff ensuring that only restraints ordered by the physician are used for residents #002 and #004 and related to completing restraint assessments and documentation of those assessments for residents #002 through #008. The interdisciplinary team did not review the ongoing need for the restraints on a monthly basis for residents #002 through #008 as per the home's policies and procedures.

C. The home's policy "Falls Prevention and Management Program #4.1.12" and it included: "Evaluate and monitor residents for 72 hours after the fall; Evaluation of the resident's condition before, during and immediately after the fall provides clues to possible causes and Risk factors related to medical conditions or medication use may be reflected in abnormal values for any of the following: Vital signs; Head Injury or Neurovital signs; Postural blood pressure and apical heart rate; Finger stick glucose and Change in cognition." The policy also included: "Residents should have increased monitoring for the first 72 hours after a fall; Each shift the nurse should record in the progress notes a review of symptoms, noting any worsening or improvement of symptoms as well as the treatment provided. Reference to the fall should be clearly documented in the progress note."

i) The record of resident #002 was reviewed including documentation related to four falls that were unwitnessed, two of which occurred during 2013 and two occurred during 2014. One of the 2014 falls resulted in bruising of resident #002 which lasted over one month. There was no documentation of head injury routine found in the record with respect to the four unwitnessed falls of identified resident #002.

ii) The DOC was interviewed and confirmed that it was the expectation of the home that when a resident had an unwitnessed fall or a fall resulting in head injury the resident's neurovital signs are to be assessed and documented in the resident's record for the first 72 hours after the fall.

iii)The DOC was requested to produce documentation of head injury routine related to the unwitnessed falls of resident #002 and they did not produce the documentation. They reported that the documentation was not available and that perhaps the resident refused in some instances and that if the resident refused assessment of their neurovital signs, the refusals were not documented by staff.

iv) The home did not follow the policies and procedures related to assessment of and documentation of neruovital signs related to head-injury routine post unwitnessed falls for resident #002. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
The home's complaints policy was in compliance with all applicable requirements under the Act specifically; Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.
The home's written complaints policies and procedures are followed specifically; providing annual staff education related to addressing questions and responding to complaints; providing complainants a written response within ten business days of the receipt of the written complaint and for documenting the following: The type of action taken to resolve the complaint, including date of action, time frames for actions to be taken and any follow-up action required; The final resolution, if any; Every date on which any response was provided to the complainant and a description of the response, and any response made in turn by the complainant are followed.
That the policies and procedures related to restraints including, ensuring that the Registered Nursing Staff ensure that only restraints ordered by the physician are used and that the Registered Nursing Staff complete restraint assessments and documentation of those assessments and that the interdisciplinary team reviews the ongoing need for the restraints on a monthly basis are followed.
That the policies and procedures related to head injury routine assessment and documentation, post unwitnessed falls are followed, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. The Inspector requested that the home produce the records of the home's 2013 annual mandatory staff training in the above areas that was provided to staff. The home did not produce any records related the required annual staff training sessions.

B. The Director of Care (DOC) was interviewed and reported that: The mandatory staff training was not provided to the staff in 2013 as there were some issues and or challenges with the education program. The home decided to use the services of a outside service provider to deliver the required training to the staff starting in August, 2014 and that the DOC has provided some of the 2014 staff training.

C. The home failed to ensure that in 2013, all staff who provided direct care to residents, as a condition of continuing to have contact with residents, received training in the following areas: Abuse recognition and prevention; Mental health issues, including caring for persons with dementia; Behaviour management; How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations; Palliative care; Falls prevention and management; Skin and wound care; Continence care and bowel management; Pain management, including pain recognition of specific and non-specific signs of pain; For staff who apply physical restraints or who monitor residents with physical devices, training in the application, use and potential dangers of these physical devices and for staff who apply Personal Assistance Services Devices (PASDs) pr monitor residents with PASDs, training in the application, use and potential dangers of the PASDs [s. 76. (7)]

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 staff who provided direct care to residents, as a condition of continuing to have contact with residents, receive training in the following areas: Abuse recognition and prevention; Mental health issues, including caring for persons with dementia; Behaviour management; How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations; Palliative care; Falls prevention and management; Skin and wound care; Continence care and bowel management; Pain management, including pain recognition of specific and non-specific signs of pain; For staff who apply physical restraints or who monitor residents with physical devices, training in the application, use and potential dangers of these physical devices and for staff who apply Personal Assistance Services Devices (PASDs), monitor residents with PASDs, training in the application, use and potential dangers of the PASDs, to be implemented voluntarily.

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

s. 110. (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:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

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

A. Resident #002 was observed in a gerichair with a table top and seatbelt applied in the dining room and in the lounge area in front of the nursing station on multiple occasions throughout the inspections.

The resident's record was reviewed and the physician's restraint order for June, 2014 was for a 10 pound (lbs) seatbelt for safety three times daily. Resident #002's Progress Note documentation of February, 2014 indicated that the staff was not able to apply the seatbelt and were using gerichair. Progress Note documentation of May, 2014 included: That the resident could no longer be transferred from wheelchair to dining room chair due to change in status. A gerichair was being used in the main dining room to stop the resident from leaving dining room and bothering other residents.

The Nurse in Charge and the Resident Assessment Instrument Coordinator (RAI Coordinator) were interviewed and they confirmed that the resident was using a

gerichair with table top restraint and seatbelt restraint in the gerichair and that there was no physicians' order for the use of the gerichair and table top restraint or for the use of the seatbelt restraint in the gerichair. They confirmed that the physician's restraint order for resident #002 was for a 10 pound seatbelt restraint on their wheelchair. Also that the resident did not use their wheelchair with the ten pound restraint.

B. Throughout the inspection resident #004 was observed in a wheelchair using a front-closing seatbelt restraint in their wheelchair.

The resident's record was reviewed including the Physicians' Medication Review and Physician Consolidated Orders for November 2013, February, 2014 and May, 2014. There were no physician's orders related to the use of a restraint for resident #004 on any of the above Physicians' Medication Reviews and or Consolidated Orders (Chart) Reports.

The Nurse in Charge and the RAI Coordinator were interviewed and they confirmed that resident #004 was using a seatbelt restraint for over one year and that there was no physician's order for the restraint.

The home obtained an order for a front-closing seatbelt restraint from the Nurse Practitioner(NP) after identification by the inspector.

The home failed to ensure that for residents #002 and #004, the staff only applied physical restraining devices to residents that were ordered or approved by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

2. The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances as evidenced by:

The records of residents #002, #003, #004, #005, #006, #007 and #008 were reviewed including restraint documentation.
The July, 2014 Medication Administration Record (MAR) for resident #002 was reviewed and the documentation indicated that the restraint order was for a ten pound

seatbelt for safety. The staff signed for the assessment of the resident's condition and for the evaluation of the effectiveness of a ten pound seatbelt restraint every eight hours when the actual restraints the resident was using was a gerichair with tabletop restraint and a seatbelt restraint. There was no documentation related to the evaluation of the effectiveness of the physical restraint that the resident was using.

The July, 2014 Medication Administration Record(MAR) of resident #004 was reviewed and there was no documentation of any assessment of the resident's condition or of any evaluation of the effectiveness of the seatbelt restraint that was being used for the resident.

The July, 2014 MAR of residents #006, #007 and #008 were reviewed and the documentation indicated that the assessment of the resident's condition and the evaluation of the effectiveness of the resident's restraint being completed two times per day rather than every eight hours.

The home failed to ensure that a member of the registered nursing staff reassessed the condition of residents #002, #004, #006, #007 and #008 and evaluated the effectiveness of their restraining at least every eight hours. [s. 110. (2) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff only apply the physical device that has been ordered or approved by a physician or a registered nurse in the extended class and to ensure that the resident's condition is reassessed and the effectiveness of restraining be evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #4: 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 or pursuant to the common law duty referred to in section 36 of the Act was undertaken on a monthly basis; that at least once in every calendar year, an evaluation was made 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 any restraining that was necessary was done in accordance with the Act and this Regulation; that the results of the analysis undertaken under clause (a) were considered in the evaluation and that the changes or improvements under clause (b) were promptly implemented as evidenced by:

The DOC was interviewed and reported that the home did not perform a monthly analysis of the restraining of residents by use of a physical device and that the home did not evaluate the effectiveness of the home's restraint program at least once in 2013.

The home did not perform a monthly analysis of the residents who were restrained by physical devices in the home. The home did not perform an annual evaluation of the effectiveness of the restraint program in 2013. [s. 113.]

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 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; 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; that the results of the analysis undertaken under clause (a) are considered in the evaluation; that the changes or improvements under clause (b) are promptly implemented and 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act as evidenced by:

A. An identified resident #002 was observed throughout the inspection sitting in a gerichair with table top restraint and seatbelt restraint in the dining room and in the lounge in front of the nursing station.

The resident's record was reviewed and progress note documentation of February, 2014 noted that the staff was unable to apply seatbelt, and were using a gerichair. Progress note documentation of May, 2014 indicated that a gerichair was being used in the main dining room to stop the resident from leaving the dining room and bothering other residents.
The resident's record did not include a physician order for the gerichair with table top restraint. The physician orders for resident #002 was for a ten pound seatbelt restraint for safety three times daily. The resident's record did not include the consent of the resident's Power of Attorney (POA) for the use of the gerichair with table top restraint. The resident's record contained documentation of the consent of their POA for a ten pound seatbelt restraint dated February, 2010.
The resident's Point-of-Care(POC)documentation and Medication Administration Record(MAR)documentation by nursing department staff contained documentation related to the seatbelt in wheelchair restraint. There was no documentation of registered staff assessment and evaluation of the gerichair restraints. No information was found in the resident's MAR or POC documentation specific to the gerichair with table top restraint and seatbelt restraint that was being used in the resident's care.

The Nurse-in-Charge and the RAI Coordinator were interviewed and they confirmed that the home did not have a physician's order for use of the gerichair with table top and seatbelt restraint for the resident #002 and that the home did not have the consent of the resident's POA for the use of the above restraint. They denied knowing which staff member made the decision to change the restraint or exactly when the use of the gerichair with table top and seatbelt restraints were started. They reported that the resident no longer used their wheelchair with the seatbelt restraint.

B. Resident #004 was observed throughout the inspection sitting in a wheelchair with a seatbelt restraint which was engaged.
The record of resident #004 was reviewed and it did not contain a physician's order for the restraint. The record did not contain documentation of the registered staff assessment and evaluation of the resident's seatbelt restraint nor the documentation of the release of the restraint nor the repositioning of the resident.

The Nurse in Charge and the RAI Coodinator were interviewed and they reported that the resident used a seatbelt restraint when in wheelchair for over one year. They confirmed that the home did not have a physician's order for using a restraint in the care of resident #004. They also confirmed that there was no documentation of the

assessment and evaluation of the restraint by registered staff every eight hours in the Medication Administration Record (MAR) and that there was no documentation of the release of the restraint nor the repositioning of the resident.

The home obtained an order for the seatbelt restraint from the Nurse Practitioner(NP) after identification by the inspector that there was no order by a physician or NP for the seatbelt restraint that was being used in the care of resident #004.

The home failed to ensure that residents #002 and #004 were not restrained, except in the limited circumstances provided for under the Act and subject to the requirements provided for under the Act. [s. 3. (1) 13.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff who provided direct care to the resident as evidenced by:

An identified resident #002 was observed sitting in a gerichair with table top restraint and with a seatbelt restraint applied to them in the dining room and in the lounge area in front of the nursing station on multiple occasions throughout the inspection.

The resident's plan of care document that the home uses to provide directions to staff who provide direct care to the resident was reviewed.
Under the focuses of eating and of supervision for eating, the plan of care included; the resident will stay in gerichair during meals to encourage the resident to eat and to avoid physical responsive behaviors toward other residents and staff.
Under the focus of potential for ulceration of skin, the interventions included; the

resident wears ten pound seatbelt restraint when in wheelchair, undo, reapply restraint at least hourly. Reposition the resident, attend to their needs for hunger, thirst, toileting and document in the restraint record every hour including the resident's response to the restraint.
Under the focus of risk for falls, the information included; the resident requires a seatbelt restraint on wheelchair and two assist rails when in bed. There was no information related to the gerichair with table top restraint with seatbelt under the risk for falls.

The Medication Administration Record(MAR) and Point-of-Care(POC) documentation by nursing department staff, for the resident #002 was reviewed and there was no information found related to the the resident's use of the gerichair with table top restraint and seatbelt restraint. They included information related to the ten pound seatbelt restraint.

The Nurse-in-Charge and the RAI Coordinator were interviewed and they reported that the resident did not use their wheelchair with the ten pound restraint. The resident primarily only got out of bed for meals. The resident was switched to using the gerichair with table top restraint to facilitate them eating and not disrupting other residents during meals. The resident had an order for a seatbelt restraint and the staff apply the seatbelt restraint while resident is in the gerichair. After the meal, the resident is placed in front of the nursing station so that they can be monitored by staff until the staff can transfer them safely back to bed otherwise, the resident will attempt to self transfer and could fall and result in injury.

The home failed to ensure that the plan of care for resident #002 set out clear directions to staff who provided direct care to the resident. [s. 6. (1) (c)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director as evidenced by:

The home received two letters of complaint in June, 2014 and July, 2014 from the family member of an identified resident #002 which were reviewed. The two letters included the family member's concerns related the care of resident #002.

The home's record was reviewed including the Complaint Log and Response (2014) and it contained some information related to the complaint letter that the home received in June, 2014 from the family member of resident #002.

The Director of Care (DOC) was interviewed and reported that the home received two letters of complaint in 2014 from the family member of an identified resident #002. The two letters included the family member's concerns related the care of resident #002. The DOC confirmed that the home did not submit a copy of the complaint letters to the Director.

The home failed to ensure that copies of the complaint letters related to the care of resident #002 were forwarded to the Director. [s. 22. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by the use of a physical device may be included in a resident's plan of care only if all of the following were satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining as evidenced by:

A. An identified resident #002 was observed sitting in a gerichair, with a seatbelt applied and engaged and a table top attached to the gerichair throughout the inspection.

i) The record of resident #002 was reviewed and it did not contain a physician's order for the use of a gerichair or the table top. The January, March and June, 2014 Quarterly Physician Medication and Treatment Reviews for resident #002 were reviewed and the physician's restraint orders were for a ten pound seatbelt for safety three times daily every day.

ii) The July, 2014 Medication Administration Record (MAR) of resident #002 was reviewed and nursing staff signed for assessment and evaluation where the resident's restraint order is noted as ten pound seatbelt for safety.

iii) The Resident Assessment Instrument Coordinator and the Nurse-in-Charge were interviewed and they confirmed that the resident's physician did not order the gerichair and table top and that the physician ordered a ten pound seatbelt for use on the wheelchair of resident #002. They denied knowing who initiated the use of the gerichair with table top and seatbelt restraints and when the use of the restraints started.

B. An identified resident #004 was observed in a wheelchair with a seatbelt applied and engaged throughout the inspection.

i) The record of identified resident #004 was reviewed including the November 2013, February 2014 and May 2014 Quarterly Physician Medication and Treatment Reviews and they did not contain a physician order for a restraint.
The Medication Administration Record of resident #004 was reviewed and it did not contain information related to the restraint.

ii) The Nurse-in-Charge and the RAI Coordinator were interviewed and they confirmed that there was no physician's order available for the use of a restraint for resident #004. The home obtained an order from the Nurse Practitioner(NP)for the use of a front-closing seatbelt in the wheelchair of resident #004 after identification by the Inspector.

The home failed to ensure that the restraining of residents #002 and #004 by a physical device may be included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. [s. 31. (2) 4.]

2. The licensee failed to ensure that the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent as evidenced by:

Resident #002 was observed using a gerichair with table top restraint and a seatbelt restraint while in the dining room and while sitting in the lounge area in front of the nursing station throughout the inspection.

The resident's record was reviewed and it did not contain documentation of the Power of Attorney (POA) consent for the use of a gerichair with table top restraint and a seatbelt restraint in the gerichair. The Consent, Authorization, Refusal for Restraint Form indicated: "Table top at meals, seatbelt when not at meals on gerichair" was not signed by the resident's POA. Inspector found one Consent, Authorization and Refusal for Restraint Form which was signed by the resident's POA. It was dated February, 2010 and the type of restraint section indicated: "Ten pound seatbelt in wheelchair and two bed rails when in bed".

The Nurse in Charge and the RAI Coordinator were interviewed and they reported that the home have left multiple voicemail messages requesting that the POA contact the home and make arrangements to sign the restraint consent form but that the POA has not visited the home to do so. The DOC was interviewed and reported that he POA has visited the home and delivered letters of complaint to the home.

The home failed to ensure that the restraining of the resident #002 had been consented to by their POA. [s. 31. (2) 5.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgment of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances as evidenced by:

The homes Complaint Log and Response 2014 was reviewed and it was noted that in June, 2014 a complaint letter was received from the family member of resident #002. The Response column of the Complaint and Response Log was blank. There was no information entered in the area related to the home's response to the letter.

The Director of Care (DOC) was interviewed and reported that they did investigate the family member's concerns. They provided documentation that in July, 2014 they attempted to contact the family member of resident #002 by telephone and were unsuccessful so they left a voicemail message regarding the letter. They also left voicemail messages for the resident's family member on two other occasions in July, 2014. The family member wrote a second complaint letter to the home in July, 2014.

The home did not provide an acknowledgment to the family member of resident #002 within 10 business days of receipt of the complaint letter, including the date by which the complainant can reasonably expect a resolution, and a follow-up response was not made to the complainant as soon as possible in the circumstances. [s. 101. (1) 2.]

Issued on this 9th day of September, 2014

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