Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 13, 2018	2018_597655_0004	000950-18, 002612-18, 005209-18	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Carlingview Manor
2330 Carling Avenue OTTAWA ON K2B 7H1

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

MICHELLE EDWARDS (655)

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): March 6, 7, 8, 9, 2018; and, March 12, 13, 14, 15, 16, 2018.

During the inspection, the following logs were inspected concurrently: 000950-18, 002612-18, 005209-18.

During the course of the inspection, the inspector(s) spoke with residents and family members, Personal Support Workers (PSWs), registered nursing staff, including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), the Physiotherapist (PT) and Occupational Therapist (OT), a Registered Dietician (RD), Associate Director's of Care (ADOCs), the Director of Care (DOC), the Assistant Executive Director (AED), and Executive Director (ED).

During the inspection, the inspector also observed the provision of resident care and services, reviewed resident health care records, and relevant policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff and others involved in different aspects of resident #001's care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Inspector #655 reviewed the health care record belonging to resident #001. According to the health care record, resident #001 passed away on a specified date. The cause of death, as identified in the resident's health care record, was a specific respiratory condition. On review of the health care record, Inspector #655 noted that communication with the physician occurred five days prior to the resident's passing with regards to a change in the dose of a specified medication that was to be used to treat resident #001's condition; and, communication with the physician occurred again on the day of resident #001's death. There was no other documentation related to communication with resident #001's physician.

Inspector #655 reviewed the progress notes in resident #001's health care record.

Over a period of time, resident #001 was described in the progress notes as exhibiting several specific symptoms related to a specified respiratory condition. In a progress note entered two days prior to the resident's passing, it was indicated that resident #001 had refused to eat one of the meals offered on that day. There were no entries made in the progress notes on the day before resident #001's passing. In a progress note entered on the day of resident #001's passing, resident #001 is described as having a sudden change in status. According to the same progress note, resident #001 is described as exhibiting several symptoms associated with the change in condition. According to the progress notes, resident #001 subsequently passed away the same day.

During an interview, PSW #109 recalled that a family member of resident #001 expressed concern about one of resident #001's specific symptoms related to a respiratory condition. PSW #109 described resident #001's symptom in a way that was not reflected in the resident's progress notes.

Over the course of the inspection, PSW #109 and PSW #101 described resident #001's normal or baseline status, specifically related to oral intake. According to PSW #101, resident #001 exhibited a change in oral intake the day prior to the resident's passing. PSW #101 further indicated to Inspector #655 that on the day before resident #001's passing, resident #001 was in bed for the majority of the day. PSW #101 further indicated

to Inspector #655 that on the day of resident #001's passing, resident #001 remained in bed due to the resident's condition. According to the PSW staff who were interviewed, the resident's oral intake was regularly documented via an electronic charting system.

Inspector #655 reviewed the above-described documentation completed by PSW staff in a specified month, up to and including the documentation completed on the day of resident #001's passing. The documentation related to oral intake by resident #001 was consistent with a change in intake as described by PSW #101.

Inspector #655 also reviewed a document used by registered nursing staff on resident #001's resident home area for the purpose of monitoring and recording residents' symptoms. Resident #001 was identified on the document. On the document, staff are prompted to identify which signs and symptoms are exhibited by each resident who is identified by placing a check-mark under applicable signs and symptoms. According to resident #001's progress notes, resident #001 exhibited several of the possible signs and symptoms. However, there was no indication on the document used to monitor and record residents' symptoms that resident #001 had experienced them.

During an interview, RPN #103 recalled that a family member of resident #001 had expressed concern to them that resident #001 was at risk for a specific complication. The family member of resident #001 recalled reporting that resident #001 was exhibiting specified symptoms related to a respiratory condition.

The family member of resident #001 indicated that this concern was reported to staff including the day and evening nurses and a PSW staff member three, and two days prior to resident #001's passing.

During an interview, RPN #110 indicated to Inspector #655 that they were working on resident #001's resident home area the day before and the day of resident #001's death. RPN #110 indicated to Inspector #655 that they had not worked on resident #001's resident home area for a period of time; and for that reason, they were not familiar with the resident's baseline status. At the same time, RPN #110 indicated to Inspector #655 that they had not been aware of any change in resident #001's status on the day prior to the resident's passing; and therefore, did not assess resident #001 that day. Specifically, RPN #110 indicated to Inspector #655 that they were not aware of a change in the resident's oral intake, and would not have reviewed the PSW documentation unless a concern had been brought forward. At the time of the interview, RPN #110 could not recall whether the document used by registered staff to monitor and record resident's

symptoms had been available for review at the time. At the time of the interview, RPN #110 indicated to Inspector #655 that they had not received any information from the night nurse during shift-report related to resident #001's status, recalling that another co-resident was identified as being unwell during report and for that reason, the focus was on the co-resident.

During an interview, the DOC indicated to Inspector #655 that there is a shift-report document that is used by registered nursing staff for the sharing of resident information between shifts. In the presence of Inspector #655, the DOC reviewed the shift-report documents for a specified period. The DOC referred to information which was contained within the various shift reports related to the resident's condition. According to the DOC, there was a report of the resident's status on the shift-report document used two days prior to the resident’s passing, which identified that resident #001 had not eaten a meal that shift. According to the DOC, there was no information related to resident #001's condition noted on the shift-reports after this time. The next shift report which included information related to resident #001's status was for the day of resident #001’s death.

The licensee has failed to ensure that staff and others involved in different aspects of resident #001's care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

2. The licensee has failed to ensure that staff and others involved in the different aspects of resident #005’s care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Inspector #655 reviewed the health care record belonging to resident #005. According to the health care record, resident #005 had a history of falls.

During an interview, a family member of resident #005 expressed concern related to the implementation of effective falls prevention strategies. According to the family member of resident #005, a specified intervention had been recommended by staff and agreed upon; but, was not implemented. According to the family member of resident #005, when the resident experienced another fall, the specified intervention was not in place. The family member of resident #005 indicated to Inspector #655 that at the time of the subsequent fall, PSW # 112 informed them that the specified intervention had not yet been implemented because it had not yet been authorized by a physician. During an interview, PSW #112 indicated the same.

According to the progress notes, the family member of resident #005 requested the use of the specified intervention on a specific date. In a progress note entered by the RN on the same day, it is indicated that another member of the health care team would be asked to assess the resident for the use of the specified intervention.

In a progress note entered on the following day by the above-noted member of the health care team, it is indicated that resident #005 would require a referral to a different member of the health care team. In a progress note entered on the same day by the second member of the health care team, it is indicated that the physician must first provide an order for the specified intervention. During an interview, this staff member indicated to Inspector #655 that they had no role in assessing resident #005 for the potential use of the specified intervention. The staff member further indicated to Inspector #655 that they had had no verbal communication with the registered nursing staff with regards to the potential implementation of the specified intervention for resident #005, or with regards to the information contained in the progress note they had entered.

On review of the resident's health care record, Inspector #655 found that an order was written for the specified intervention by the physician over two weeks later. The order was written after the resident had another fall.

During an interview, RPN #114 indicated to Inspector #655 that they had not been aware of the above-noted progress note entered by the second member of the health care team, related to the need to involve a physician before implementing the specified intervention as requested by the family member of resident #005. RPN #114 was unable to determine when the resident's physician was first notified of the request for the specified intervention on review of the resident's health care record.

In the two weeks following the initial request for the specified intervention by the family member of resident #005, no other related documentation was found.

During an interview, ADOC #115 confirmed that an order was obtained for the specified intervention on a specified date, two weeks after the family member of resident #005 made the initial request. ADOC #115 indicated to Inspector #655 that prior to that time, they had been unaware of the need to assess the resident for the potential use of a specified intervention.

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 staff and others involved in different aspects of residents' care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with Ontario Regulation 79/10, s. 229 (8), the licensee was required to ensure that there was an outbreak management system in place for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols, communication plans, and protocols for receiving and responding to health alerts; and, that there was a written plan for responding to infectious disease outbreaks.

Specifically, the licensee has failed to ensure that the following policies were complied with:

i. "Outbreak Roles and Responsibilities Checklist" (no date), as provided to the Inspector by the Assistant Executive Director; and,
ii. "Influenza Policy and Procedure" (2017-2018), as provided to the Inspector by ADOC #106.

According to the above noted policy titled "Outbreak Roles and Responsibilities Checklist", registered nursing staff are to monitor symptoms of infectious illness in residents, and to complete the daily outbreak line listing report.

During the inspection, the AED provided Inspector #655 with a copy of the "Respiratory Outbreak Line Listing For Residents" that was implemented on a specific resident home area during a respiratory outbreak that occurred during a specified month. On the line listing document, there are spaces to identify whether any of the following symptoms were being exhibited for a particular resident: fever or abnormal temperature, new/dry/increased cough, runny nose/sneezing, stuffy nose/congestion, sore throat/hoarseness/difficulty swallowing, swollen/tender glands in neck, new/increased sputum congestion, pain in chest with breathing or coughing, new/increased shortness of breath, tiredness, muscle aches, loss of appetite, headache, and worsening functional or mental status.

Inspector #655 reviewed the health care records of three residents, including the progress notes and documentation completed by PSW staff.

According to the health care record, the first resident exhibited five specific symptoms over a period of 12 days.

The documentation on the above-noted line listing document, which had been implemented for the first resident's resident home area, was indicative that the resident was identified as having exhibited only one of the above-noted symptoms. There was no documentation on the line listing document to reflect that the first resident had at any time exhibited the four other symptoms.

According to the health care record belonging to the second resident, the second resident exhibited four specific symptoms over a period of six days. However, there was no documentation on the line listing document to indicate that the second resident had at any time exhibited two of the four symptoms.

According to the health care record belonging to the third resident, the third resident exhibited three symptoms over a period of 10 days. There was no indication on the line listing document to indicate that the third resident had at any time exhibited one of the three symptoms.

The licensee failed to ensure that the policy titled "Outbreak Roles and Responsibilities Checklist" was complied with.

In addition to the above, the licensee failed to ensure that the policy titled "Influenza Policy and Procedure" (2017-2018) was complied with.

In the policy titled "Influenza Policy and Procedure" (2017-2018), dosing guidelines for a specified medication are outlined. According to the policy, a prophylactic dose of the medication is to be initiated within 48 hours of contact with another infected individual and is to continue until the outbreak is over. According to the same policy, a treatment dose of the medication is to be initiated within 48 hours of symptom onset. It is noted within the policy, that variation in dosing may be required depending on a resident's renal function.

Inspector #655 reviewed the health care recording belonging to two specific residents, including progress notes and Medication Administration Record (MAR) for a specified month.

According to the health care record, the first resident exhibited two or more symptoms on a specified date. Over the course of the inspection, this was confirmed during interviews with RPN #103 and ADOC #107.

According to the first resident's MAR, however, the first resident was given the prophylactic dose of the medication for a period of four days, after the resident had already exhibited two or more of the relevant symptoms three days before the prophylactic dose was initiated. According to the same MAR, the first resident was not given the treatment dose of the medication until approximately one week after symptom onset. During an interview, ADOC #106 indicated the same.

During interviews, both AED #105 and DOC #111 indicated to Inspector #655 that the protocol related to the medication was expected to be implemented, as per the above-noted policy. Both AED #105 and DOC #111 further indicated to Inspector #655 that the first resident was expected to receive the treatment dose of the medication, as opposed

to prophylactic dose, starting on the same day that the resident first exhibited two or more symptoms.

According to the second resident's health care record, the second resident exhibited two or more symptoms as of a specified date. According to the residents MAR, however, the resident was not given the treatment dose of the medication until four days after symptom onset.

The licensee failed to ensure that the policy titled "Influenza Policy and Procedure" (2017 -2018) was complied with in regards to the administration of a specified medication.

2. In accordance with Ontario Regulation 79/10, s. 30 (1) 1, the licensee was required to ensure that with respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulations, there was a written description of the program that included its goals and objectives and relevant policies, procedures, and protocols. Under section 48 of Ontario Regulation 79/10, the licensee was required to ensure that an interdisciplinary falls prevention and management program was developed and implemented in the home.

The licensee has failed to ensure that the policy titled "Fall Prevention and Injury Reduction" (CARE5-010.05, dated October 14, 2016), as provided to Inspector #655 by ADOC #106 was complied with.

According to the above-noted policy titled "Fall Prevention and Injury Reduction" (CARE5 -010.05, dated October 14, 2016), an interdisciplinary team huddle (or "Post-Fall Huddle") is to be conducted on the same shift that the fall occurred. In the same policy, it is indicated that the "Post-Fall Huddle Questions" are to be used to collect the information needed to conduct a root cause analysis of the fall.

During an interview, a family member of resident #005 expressed concern related to the implementation of effective falls prevention strategies, noting that resident #005 had had several falls since admission to the home.

Inspector #655 reviewed the health care record belonging to resident #005. According to the health care record, resident #005 had three falls over a four week period.
On review of resident #005's health care record, Inspector #655 was unable to locate any documentation in the electronic or hard-copy health care record that would demonstrate that a "Post-Fall Huddle" had been completed after two of the three falls.

During an interview, RPN #114 was unable to speak to when the "Post-Fall Huddle" was expected to be completed. RPN #114 indicated that their own practice would be to complete a "Post-Fall Huddle" each time an unwitnessed fall occurred. RPN #114 was unsure whether a "Post-Fall Huddle" was required when a fall was witnessed. At the same time, RPN #114 indicated to Inspector #655 that if a "Post-Fall Huddle" had been completed after the above-noted falls, the documentation would be found in the resident's hard-copy health care record.

During interviews, both ADOC #115 and DOC #111 indicated to Inspector #655 that the "Post-Fall Huddle" was expected to be completed after every fall.

The licensee has failed to ensure that the policy titled "Fall Prevention and Injury Reduction" (CARE5-010.05, dated October 14, 2016) was complied with. [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 identified policies are complied with, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care for resident #005 included an order by the physician or the registered nurse in the extended class related to the use of a bed rail restraint.

Over the course of the inspection, Inspector #655 observed resident #005 and the bed system belonging to resident #005. On three separate occasions, Inspector #655 observed bed rails to be in the up position.

During an interview, PSW # 112 indicated to Inspector #655 that bed rails were in place for resident #005. According to PSW #112, the bed rails were being used to prevent resident #005 from getting out of bed.

Inspector #655 reviewed the health care record belonging to resident #005. According to the health care record, the above-described bed rails were implemented for resident #005 on a specified date, at the request of the resident's SDM. On review of the resident's health care record, Inspector #655 was unable to locate a physician's order for the use of a bed rail restraint for resident #005.

During an interview, RPN #114 recalled that a family member of resident #005 had requested the use of bed rails for resident #005. RPN #114 was otherwise unable to speak to the use of the bed rails for resident #005, explaining that ADOC #115 had performed the follow-up with regards to the family member's request.

During an interview, ADOC #115 indicated to Inspector #655 that the bed rails were implemented for resident #005 in order to prevent the resident from getting out of bed. At the same time, ADOC #115 confirmed that when resident #005's bed rails were implemented, there had been no physician's order.

The licensee has failed to ensure that the restraint plan of care for resident #005 included an order by the physician or the registered nurse in the extended class related to the use of a bed rail restraint. [s. 31. (2) 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 to ensure that the residents restraint plan of care includes an order by the physician or the registered nurse in the extended class, to be implemented voluntarily.

WN #4: 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):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of an unexpected or sudden death, followed by the report required under subsection 4.

Inspector #655 reviewed the health care record belonging to resident #001. According to the health care record, resident #001 passed away on a specified date. There was no indication based on a review of the health care record that resident #001 was at the end-stage of a disease, or that resident #001 had been deemed to require comfort measures only.

Over the course of the inspection, the death of resident #001 was described by staff, including ADOC #107, as being unexpected and/or sudden.

Inspector #655 was unable to locate a Critical Incident Report (CIR) related to this incident, or any other record that would demonstrate that the Director was immediately

informed of the death of resident #001.

Inspector #655 also reviewed the health care record belonging to resident #003.

According to the electronic health care record, resident #003 passed away on a specified date. There was no indication on review of the resident's electronic health care record that resident #003 was at the end-stages of a disease or that the resident was deemed to require comfort measures only.

During an interview, ADOC #106 indicated to Inspector #655 that resident #003 was not at the end-stages of life at the time of the resident's death.

Inspector #655 was unable to locate a CIR related to this incident, or any other record that would demonstrate that the Director was immediately informed of the death of resident #003.

Over the course of the inspection, DOC # 111 confirmed that the deaths of resident #001 and of resident #003 were unexpected. DOC #111 further indicated to Inspector #655 that they were not aware of a CIR having been submitted to the Director under the Long-term Care Homes Act, 2007, with regards to the unexpected death of resident #001 or of resident #003.

The licensee failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of the unexpected or sudden deaths of resident #001 and resident #003. [s. 107. (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 the Director is immediately informed of an unexpected or sudden death, to be implemented voluntarily.

WN #5: 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. (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:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint documentation for resident #005 included all assessment, reassessment, and monitoring, including the resident's response; and, every release of the device and repositioning of resident #005.

On a specified date, Inspector #655 observed resident #005 to be seated with a specified physical device in place. At the time of the observation, the physical device was not positioned correctly on resident #005. Inspector remained with the resident until two PSW staff were able to reposition the resident and re-apply the device. Resident #005 was observed again, on another specified date, to be seated with the same physical device in place.

Inspector #655 reviewed the health care record belonging to resident #005. According to the health care record, resident #005 was to have a physical device in place when seated, in accordance with the request of a family member, related to a specific risk. On review of the progress notes, Inspector #655 found that resident #005 was described as not maintaining an appropriate position when seated.

During an interview, PSW #112 indicated to Inspector #655 that the physical device was

in place for the purpose of preventing resident #005 from getting up voluntarily. At the same time, PSW #112 indicated to Inspector #655 that resident #005 does not always sit appropriately with the device in place. PSW# 112 spoke to the regular monitoring of resident #005 when the device is in place, and the need to release the resident and reposition the resident every two hours. According to PSW #112, this information is to be documented by staff via the electronic charting system.

During an interview, RPN #114 indicated to Inspector #655 that PSW staff are expected to monitor the resident every hour when the physical device is in place, and to reposition the resident every two hours. RPN #114 indicated that PSW staff are to document this information electronically. At the same time, RPN #114 indicated to Inspector #655 that resident #005 does not always maintain an appropriate position while seated.

Inspector #655 reviewed the documentation completed by PSW staff for resident #005 during a specified month, and was unable to locate any documentation that was indicative of: who had applied the device, when the device was released or when the resident had been repositioned. On review of resident #005's health care record, Inspector #655 was also unable to identify any documentation related to the resident's response to the physical device.

During an interview, ADOC # 115 and ADOC #106 indicated to Inspector #655 that where the hourly monitoring of the resident had been documented in the electronic charting system, the times associated with the entries were reflective of the time at which the documentation was completed, as opposed to the time at which the resident was monitored or observed. In addition, ADOC #106 indicated to Inspector #655 that usually, staff are expected to document each time the device is applied and each time it is removed; as well as each time the resident is released and repositioned. However, according to DOC #106, this task had not been entered into the electronic charting system; and therefore, the documentation had not occurred. ADOC #106 further indicated to Inspector #655 that there was no documentation specifically related to resident #005's response to the physical restraint device.

The licensee has failed to ensure that the restraint documentation for resident #005 included all assessment, reassessment, and monitoring, including the resident's response; and, every release of the device and repositioning of resident #005. [s. 110. (7) 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 restraint documentation includes all assessment, reassessment, and monitoring, including the resident's response; and, every release of the device and repositioning of the resident, to be implemented voluntarily.

Issued on this 17th day of May, 2018

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

Original report signed by the inspector.