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

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Inspection de soins de longue durée

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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
Jul 21, 2017	2017_627138_0018	005942-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF LANARK
P.O. Box 37 Sunset Blvd. PERTH ON K7H 3E2

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

LANARK LODGE
115 Christie Lake Road, R. R. #4 Lot 27, Concession 2 PERTH ON K7H 3C6

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

PAULA MACDONALD (138), RENA BOWEN (549)

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): July 10, 11, 12, 13, 14, and 17, 2017.

The following Critical Incident Inspections were conducted as part of this RQI:
Log #000886-17 relating to an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition,
Log #008335-17 relating to alleged resident abuse and,
Log #014700-17 relating to alleged resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director, Long Term Care, both Associate Directors of Care, the Director of Care, the Food Service Supervisor, the Registered Dietitian, the Environmental Services Manager, the Chair of the Family and Friends Council, the Chair of the Residents' Council, registered nurses (RN), a housekeeping worker, registered practical nurses (RPN), personal support workers (PWS), a recreation worker, a restorative care worker, residents, and family members.

The inspectors observed residential and non residential areas of the home, observed resident to resident interactions, reviewed several policies, observed a medication pass, reviewed medication incident documentation, reviewed resident health care records, reviewed internal investigation documentation, and reviewed employee training.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **6 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to comply with section 6.(1)(c) of the Act in that the license failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide care to the resident.

The home submitted a Critical Incident Report relating to an incident of suspected sexual abuse of a resident that occurred on a specified date. The Critical Incident Report outlined that resident #046 was found in bed with resident #047. It also outlined that resident #046 was observed to be in the process of undressing resident #047.

Inspector #138 spoke with the home's Director, Long Term Care and Associate Director of Care #102 separately regarding the incident of suspected sexual abuse as outlined in the Critical Incident Report and each stated that resident #046 has specific behaviours. Both the home's Director, Long Term Care and Associate Director of Care#102 believe that resident #046's actions were not intentional in the incident but as a result of the resident #046's identified behaviour patterns.

Inspector #138 reviewed resident #046's health care record including the progress note about the incident which described that resident #046 and resident #047 were found in bed together, that resident #046 was attempting to undress resident #047, and that resident #047 was pushing resident #046's hand away to prevent the undressing. Both resident's were separated. The inspector reviewed the progress notes further and read a more recent progress note in which resident #046 was found by a staff to be standing in front of another resident with resident #046's hand on the other resident's legs. The other resident was not wearing pants at the time but did have on a brief.

Inspector #138 proceeded to the unit where resident #046 resided and spoke with several PSWs about the resident. The inspector spoke with PSW #117, PSW #118, and PSW #119 and none of these PSWs identified to the inspector any concerns related to resident #046's identified behaviours and were not able to describe any interventions in place to prevent incidents of potential sexual abuse.

Inspector #138 reviewed the plan of care, as defined by the home, for resident #046. The inspector noted that the current plan of care reviewed was last updated after the incident outlined in the Critical Incident Report and the more recent progress note mentioned above. The inspector was not able to locate any information in the plan of care regarding interventions to prevent incidents of potential sexual abuse.

As such, the licensee failed to ensure that the plan of care for resident #046 provided clear direction to staff regarding interventions to prevent incidents of potential sexual abuse.

Log #008335-17 [s. 6. (1) (c)]

2. The licensee failed to comply with section 6.(7) of the Act in that the licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #019 was admitted to the home approximately three years ago with multiple diagnosis including dementia.

The current written plan of care for resident #019 indicates that the resident is at a fall risk and is to wear proper and non-slip footwear. The written plan of care also indicates that resident #019 uses a tilt wheelchair with elevated footrests.

Resident #019 was observed on July 10, 2017, by Inspector #138 to be sitting in the tilt wheelchair (not in the tilt position) with feet on the floor wearing socks. The footrests where not attached to the wheelchair at the time of the observation. Inspector #549 observed that one of the resident's foot and leg was edematous.

On July 11, 2017 at 1400 hours, resident #019 was observed by Inspector #549 in the lounge area to be sitting in the tilt wheelchair (not in the tilt position) with feet flat on the floor not wearing any footwear and no footrest attached to the wheelchair. Restorative

Care Worker #112 indicated at the time that resident #019 is to have the footrests on and these footrests are to be in an elevated position. The Restorative Care Worker left to get the resident's footrests and elevate the resident's feet. Inspector #549 observed at the time that one of the resident's foot and leg was edematous.

On July 12, 2017, after the breakfast meal, resident #019 was observed by Inspector #549 in the lounge area sitting in the tilt wheelchair in the tilt position without footrests on the wheelchair. As the inspector approached the resident, it was observed that a PSW left the lounge to get the resident's footrests and attached them to the wheelchair in an elevated position with the assistance of another PSW. The inspector observed that the resident was wearing socks and non-slip foot wear.

During an interview with Associate Director of Care #102 on July 13, 2017, it was indicated to Inspector #549 that the home's expectation is that staff provide care as set out in the plan of care for resident #019.

The licensee failed to ensure that resident #019 received the care specified in the resident's plan of care related to footwear and the wheelchair footrests being on the wheelchair and in an elevated position. [s. 6. (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 1) to ensure that resident #046's plan of care provides clear direction to staff regarding interventions to prevent incidents of potential sexual abuse and 2) to ensure that resident #019 is provided wheelchair footrests and resident #019's feet are elevated in the footrests according to the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that the seat belt alarm used for resident #019 as part of the home's falls prevention program is used in accordance with the manufacturer's instructions.

Associate Director of Care #103, who is responsible for the falls prevention program, indicated during an interview with Inspector #549 on July 13, 2017, that the home uses seat belt alarms as part of the falls prevention program.

The product used is a CareSense Easy Release Seat belt, manufactured by Curbell Medical to alert staff when a resident who is at risk of falling has gotten up from his or her wheelchair. The seat belt alarm straps are attached to the wheelchair on both sides with screws. Both ends of the seat belt has Velcro with a red loop tab and interlocking blue plastic pieces. The interlocking plastic piece is then hooked to a monitor that will sound an alarm when the Velcro is unfastened and the plastic pieces are separated. In addition to setting off an alarm when unfastened, the seat belt also helps keep the resident from sliding down the chair.

A review of resident #019's health care record was completed by Inspector #549. The health care record indicated that resident #019 was assessed at a fall risk.

On July 11, 2017, resident #019 was observed in a tilt wheelchair (not in the tilt position) with both hands under the seat belt alarm with the straps of the seat belt alarm at the resident's forearms and sliding forward under the seat belt. There was approximately a five inch gap between the resident's waist and the seat belt.

Inspector #549 reviewed the manufacturer's instructions with Assistant Director of Care #103. The manufacturer's instructions for the seat belt alarm indicated that the seat belt is to be positioned around the resident's waist, adjusted to the desired length using the black buckle that holds the adjustment strap in place. Pull up any slack in the belt so it's secure in the buckle.

Resident #019's seat belt alarm was not applied in accordance with the manufacturer's instructions as there was an approximate five inch gap between the resident's waist and the seat belt. Resident #019 was observed sliding under the seat belt out of the wheelchair, the seatbelt was noted at chest level.

The licensee failed to ensure that the seat belt alarm for resident #019 was applied in accordance with the manufacturer's instructions. [s. 23.]

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 seat belt alarm for resident #019 is applied according to the manufacturer's instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with section 24.(1)2. of the Act in that the licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director (Ministry of Health and Long Term Care).

The home submitted a Critical Incident Report which outlined an incident of suspected sexual abuse of a resident that occurred on a specific date. The incident was not reported to the Director (Ministry of Health and Long Term Care) until three days later.

Inspector #138 spoke with the home's Director, Long Term Care regarding the incident of suspected sexual abuse and the home's Director, Long Term Care stated that the staff member in charge of the home had only reported the incident internally within the home. The home's Director, Long Term Care stated that other management of the home became aware of the incident three days later, after reading the home's internal communication and immediately reported the incident to the Director (Ministry of Health and Long Term Care) through a Critical Incident Report. The home's Director, Long Term Care stated that, as a result of this incident, redirection was provided to the staff member in charge regarding immediate reporting of suspected resident abuse.

As such, the licensee failed to ensure that the incident of suspected sexual abuse of a resident was reported immediately to the Director (Ministry of Health and Long Term Care).

Log #008335-17 [s. 24. (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 any suspected abuse is immediately reported to the Director (Ministry of Health and Long Term Care), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with section 30.(1)5. of the Act in that the licensee failed to ensure that no resident of the home is restrained by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents.

On July 13, 2017, Inspector #138 observed several resident rooms with a baby gate style barrier placed in the door frame of the entrance of the room. The inspector noted several other resident rooms that had a baby gate style barrier resting inside the room but not placed in the door frame.

Inspector #138 noted specifically that resident #056, who was independent with mobility, was observed with a baby gate style barrier at the entrance to the door of the resident's room. The inspector asked a nearby housekeeping worker if she had observed the baby gate style barrier to be in use at the door to the resident's room. The housekeeping

worker stated that she has routinely observed the baby gate style barrier in the door to the resident's room while the resident was inside the room. The inspector also spoke with a nearby PSW, PSW #101, about the baby gate style barrier seen in resident #056's room. PSW #101 stated that the baby gate style barrier is used in the door to the resident's room when resident #056 is in the room. PSW #101 also stated that the resident is not able to consistently release the baby gate style barrier and is required to rely on staff to do this.

Inspector #138 spoke with RPN #100 who was with resident #051 inside the resident's room. It was noted by the inspector at the time that there was a baby gate style barrier in place at the door to the entrance of the resident's room. RPN #100 stated that resident #051 would not be able to release the baby gate style barrier as the resident was in a wheelchair and would not be able to reach the release button. RPN #100 stated that the resident would be dependent on staff to release the baby gate style barrier.

RPN #100 also stated that the baby gate style barrier was used throughout the home for many residents. The inspector asked RPN #100 to demonstrate the use of the baby gate style barrier and the RPN demonstrated the release of the barrier from the door by depressing a release button on the handle and then pushing the barrier to the side. The inspector asked if the baby gate style barrier could be easily released by all residents who use this barrier and RPN #100 replied that not all residents would be able to release the barrier, many would require the assistance of staff.

Further, Inspector #138 spoke with Associate Director of Care #102 regarding the baby gate style barrier used in resident #046's room. Associate Director of Care #102 stated that a baby gate style barrier was used for resident #046 at night so that staff would know where the resident was. Associate Director of Care #102 stated that he was unsure if the resident could release the barrier as the resident has never been observed to try. Later, the Associate Director of Care #102 stated that resident #046 would be able to release the baby gate style barrier by kicking it out of the door frame.

Inspector #138 had further discussion with Associate Director of Care #102 who stated that the baby gate style barriers are used throughout the home and acknowledge that there are several residents who use the baby gate style barrier that would not be able to release the barrier. Associate Director of Care #102 also acknowledged that the baby gates style barrier restricted resident movement if the resident was unable to release the baby gate style barrier.

As such, the baby gate style barrier acts in restricting resident movement from the resident's respective room to other areas of the home when the baby gate style barrier is in place in the door to the residents' room and the resident is unable to independently release the baby gate style barrier. [s. 30. (1) 5.]

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 baby gate style barriers are not used to restrain residents in the residents' room, to be implemented voluntarily.

WN #5: 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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
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).
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).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with section 31.(2) of the Regulation in that the licensee has failed to ensure that restraining of a physical device may be included in a resident's plan of care only if the following are satisfied: 4. A physician, registered nurse in the extended class or other person provided for in the regulation has ordered or approved the restraining and 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.

The licensee's Least Restraint Policy # F-10.08 revision date: March 2014, provided by Associate Director of Care #103 to Inspector #549 indicates the definition of a physical restraint as: "a physical restraint includes all devices used by the home that restrict freedom of movement or normal access to one's body. Where a resident is both physically and cognitively able to release themselves from a device, this device is not considered a restraint (i.e. a seat belt which a resident can undo independently, consistently, and without difficulty)".

1. Resident #019 was admitted to the home approximately three years ago with multiple diagnosis including dementia. The current Minimum Data Set (MDS) assessment reviewed by the inspector, indicates that the resident is cognitively impaired.

Resident #019 was observed by Inspector #549 on July 10, 11 and 12, 2017, to have a seat belt alarm (CareSense Easy Release Seat Belt) applied while in a wheelchair. The manufacturer's instruction indicate that the seat belt alarm is designed to go around the resident's waist while in a wheelchair. It is to be applied with no slack in the seat belt so that it is secure in the buckle. There is a red coloured loop tab that is designed so the resident can put his/her hand in the loop and pull back that so the Velcro is pulled back and the plastic blue tabs separate, this will set an alarm off indicating to staff that the resident has removed the seat belt.

During an interview with PSW #104 and PSW #105, it was indicated to Inspector #549 that resident #019 has the seat belt alarm applied at all times when the resident is in the wheelchair.

Inspector #549 attempted to release the seat belt alarm while the resident was in the wheelchair by pulling on the seat belt forwards and sideways. The seat belt alarm would not release unless the red loop was pulled backwards releasing the Velcro to separate

the plastic blue tabs.

On July 11, 13, and 14, 2017, Inspector #549 asked resident #019 to release the seat belt. On all three occasions the resident was not able to release the seat belt. A review of the resident's health care records indicated that the seat belt alarm was first applied upon admission and the last review of the written plan of care indicated that the seat belt alarm was to remain as part of the resident's plan of care.

On July 12, 2017, during an interview with Associate Director of Care #103, it was indicated to the inspector that seat belt alarms are used as a fall prevention intervention and have not been considered a restraint. Associate Director of Care #102 and Associate Director of Care #103 indicated during an interview to the inspector that resident #019's capability to release the seat belt alarm independently, consistently and without difficulty has not been reassessed since the initial application of the seat belt alarm.

On July 13, 2017, during an interview with Associate Director of Care #102 it was indicated that resident #019 was not capable of releasing the seat belt alarm as the resident's condition has deteriorated. Associate Director of Care #102 indicated that the seat belt alarm would meet the definition of a restraint as resident #019 is not capable of releasing it and the seat belt alarm physically restrains the resident from getting out of the wheelchair.

Inspector #549 reviewed resident #019's health care records with Associate Director of Care #102 and was unable to locate an order from a physician or a registered nurse in the extended class or consent for the use of the seat belt alarm.

2. Resident #041 was admitted to the home within the last year. The resident has multiple diagnoses including dementia.

Resident #041's current MDS assessment indicates that the resident is cognitively impaired.

On July 14, 2017, Inspector #549 observed resident #041 sitting in a wheelchair with a seat belt alarm applied. The inspector asked the resident to undo the seat belt alarm. The resident attempted to undo the seat belt alarm however, was unable to do so. The resident then looked for a staff member for assistance to release the seat belt alarm.

Review of resident #041's health care records by the inspector indicated that a Physical Restraint Assessment was completed in June 2017 and that the resident had a trunk restraint at the request of the resident/Substitute Decision Marker (SDM) for safety reasons only and that there was a physician order and a consent from the SDM in the resident's health care record. The assessment also indicated that the resident was not capable of undoing the trunk restraint.

During an interview on July 14, 2017, PSW #114 who provides care to resident #041, indicated that the resident has a seat belt alarm applied at all time when in the wheelchair. PSW #114 also indicated that she documents that she is monitoring the resident every hour and repositioning the resident every two hours in the Point of Care (POC). The PSW indicated to the inspector that the resident is not capable of releasing the seat belt alarm.

Inspector #549 reviewed resident #041's health care record with Associate Director of Care #102 and was unable to locate a consent or a physician's order for the application of the seat belt alarm, however the PSWs are documenting in POC every shift that there is monitoring of the resident every hour and repositioning every two hour. The registered nursing staff are documenting that the resident's restraint/safety equipment was monitored, released and resident was repositioned as documented by the PSW and the resident has a continued need for the restraint/safety equipment.

Resident #019 and resident #041 both have a seat belt alarm applied when up in their wheelchairs. Neither resident is capable of being able to undo independently, consistently, and without difficulty the seat belt alarm as indicated by care staff. Associate Director of Care #102 and Associate Director of Care #103 indicated that the seat belt alarm does meet the definition of a restraint as indicated in the licensee's Least Restraint policy and should have an order from the physician or a registered nurse in the extended class and a consent to apply the restraint.

The license has failed to obtain an order from a physician or a registered nurse from the extended class or consent to apply the restraint from the resident's SDM when resident #019 and #041 where restrained by the seat belt alarm. [s. 31. (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 resident #019 and resident #041 both have an order from a physician or a registered nurse in the extended class and consent for restraints by the resident/SDM, to be implemented voluntarily.

WN #6: 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:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are documented: the type of restraint used, when the restraint is applied, all assessments, reassessments including the resident's response to the restraint and every release and repositioning.

During an interview with Inspector #549 on July 12, 2017, Associate Director of Care #102 indicated that the PSWs document the hourly monitoring, release and two hour repositioning in of a restraint in the Point of Care (POC) in PointClick Care (PCC) which is the home's electronic documentation system. The document is called Restraints/Personal Safety Device.

The registered nursing staff also document in POC every eight hours the reassessment and the continuing need for the restraints/personal safety device. The document is referred to as the Registered staff restraint sign off.

1. Resident #050 was admitted to the home within the last year with multiple diagnosis including dementia.

Inspector #549 reviewed resident #050's health care record which indicated that the resident was assessed to be a fall risk. There is a physician's order indicating a seat belt alarm and full bed rails as restraints. The seat belt restraint is to be applied at all times when in the resident is in a wheelchair and full bed rails on each side of the bed are to be in the up position at all times when the resident is in bed. The health care records also contained a consent signed by the resident's SDM for the seat belt alarm and full bed rails as restraints.

The Restraint/Personal Safety Device documentation in the POC states: Resident was monitored hourly and released and repositioned every two hours if restraint is use. This includes restraints and safety equipment. Check N/A if restraint or safety equipment not applied at time of required documentation. The PSWs check either yes, no, resident not available, resident refused or not application.

Inspector #549 reviewed the Restraints/Personal Safety documentation for resident #050 between July 4, 2017 and July 17, 2017. The type of restraint/personal safety device that was being monitored was not identified. The documentation does not indicate the type of restraint/personal safety device, when it was applied, every release or repositioning or removal.

The documentation in POC had a check in the yes column for the whole time period reviewed. The check did not reflect monitoring every hour or repositioning every two hours. Between July 4 and July 17, 2017, there are periods of time between three hours and eleven hours where there is no documentation at all.

The registered nursing staff complete a document in the POC titled: Registered staff restraint sign off. The document states: Resident's restraint/safety equipment was monitored, released and resident was repositioned as documented by the PSW and resident has a continued need for the restraints/safety equipment. The registered staff check either yes, no, resident not available, resident refused or not applicable.

Inspector #549 reviewed the registered nursing staff restraint sign off documentation in the POC for resident #050 between July 4, 2017 and July 17, 2017. The type of restraints/personal safety device is not identified. There is no documentation for the day shift on July 9, 2017, no documentation on July 11, 2017 for the evening shift, no documentation for the night shift July 15 or 16, 2017. There is no documentation as to the type of restraint and no documentation on any of the dates for the resident's response to the restraint

2. Resident #019 was admitted to the home approximately three years ago. The resident has multiple diagnoses including dementia.

Inspector #549 reviewed the resident's health care file which indicated that the resident was assessed at a fall risk. Restraint documentation was completed for resident #019 who has full bed rails as a restraint. There is a physician's order and a SDM consent for the full bed rails. The bed rails are to be in the up position at all times when the resident is in bed.

Review of the Restraints/Personal Safety Device documentation in POC for resident #019 between July 4 and July 17, 2017, by the inspector indicated that a yes was checked for the reviewed time period except for July 6, 2017 at 14:03 hours a check is in the not applicable column. The documentation does not indicate the type of restraints/personal safety device, when it was applied, every release or repositioning or removal.

Inspector #549 reviewed the registered nursing staff restraint sign off documentation in POC for resident #019 for the same period of time (July 4-17, 2017). There is no documentation for July 9 and 15, 2017 evening shift. There is no documentation as to the type of restraint and no documentation on any date for the resident's response to the restraint

3. Resident #041 was admitted to the home within the last year. The resident has

multiple diagnoses including dementia.

Review of the resident's health care record indicated that the resident was assessed at a specific fall risk. The resident has quarter side rails in the up position and is able to move freely when in bed. There is no physician's order for a restraint or consent for a restraint.

Review of the Restraints/Personal Safety Device PSW documentation in POC for resident #041 by the inspector between July 4 and July 17, 2017 indicated that a yes was checked for the reviewed time period. The documentation does not indicate the type of restraints/personal safety device, when it was applied, every release or repositioning or removal.

Review of the registered nursing staff restraint sign off documentation in POC indicated a check in the yes column for the same time period of July 4-17, 2017, except on July 9, 11, 15 and 16, 2017 for the evening shift. The documentation does not indicate the type of restraint/personal safety device, when it was applied, every release or repositioning or removal.

During an interview with Inspector #549 on July 14, 2017, Associate Director of Care #102 indicated that the restraint/personal safety device documentation in the POC for both the PSWs and the registered nursing staff did not indicate the type of restraints/personal safety device that was being monitored.

Inspector #549 reviewed the POC restraint documentation for both the PSWs and the registered nursing staff with Associate Director of Care #103. Associate Director of Care #103 indicated that in the Restraints/Personal Safety Device documentation in the POC for the PSWs sign off did not identify the type of restraints/personal safety device and that the documentation did not indicate when the restraints/personal safety device was applied, every release and repositioned or when the restraint/personal safety device was removed. The registered nursing staff restraint sign off documentation in POC did not identify the type of restraint or the resident's response to the restraint.

The licensee has failed to ensure that every use of a physical restraint under section 31 of the Act meets the legislative requirements related to documentation. [s. 110. (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 the type of restraint, when the restraint is applied, all assessments, reassessment including the resident's response to the restraint, and every release of the restraint and repositioning are documented for resident #019, resident #041, and resident #50, to be implemented voluntarily.

Issued on this 21st day of July, 2017

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

Original report signed by the inspector.