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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 7, 2019	2019_641665_0002	005023-18, 011885-18, 017473-18	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

Maynard Nursing Home
28 Halton Street TORONTO ON M6J 1R3

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

JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 16, 17, 18, 21, 23, 24, 25, 28, 29, 30 and 31, 2019.

The following critical incident system (CIS) intakes were inspected:
- Log #005023-18, CIS #2211-000005-18 and #011885-18, CIS #2211-000014-18, related to resident to resident abuse.
- Log #017473-18, CIS #2211-000018-18, related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Nursing Care (DNC), Assistant Director of Care (ADOC), Neighbourhood Coordinator/Personal Expression Resource Team (PERT) Lead, Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Nursing Student (NS) and residents.

During the course of the inspection, the inspector conducted resident care observations, reviewed residents' clinical records, reviewed training records and reviewed the home's policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **7 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	Légende 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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to a ensure that the following rights of residents are fully respected and promoted: 1) Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

The home submitted a critical incident system (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) for an incident that occurred on an identified date in 2018, related to staff to resident physical abuse. The CIS report indicated that resident #004 exhibited responsive behaviour and received an identified medication to manage the responsive behaviour. The report indicated that a total of five staff were required to administer the medication to resident #004.

A record review of the home's investigation notes indicated that during the medication administration, areas of resident #004's body were restrained by PSWs #110, #116 and #119 and agency RPN #117. A further review of the investigation notes indicated that PSW #119 used a specified device to prevent the resident from moving during the medication administration.

A review of resident #004's plan of care indicated the resident had a history of physically and verbally responsive behaviours towards staff and other residents.

In interviews, PSWs #110 and #116 indicated that RN #101 requested assistance to administer resident #004's medication. Both PSWs stated they restrained identified areas of the resident's body during administration of the medication. PSW #116 stated that an identified device was used on the resident to further prevent them from moving. The PSWs indicated that during the incident the resident exhibited physically and verbally responsive behaviours towards staff. PSWs #110 and #116 stated they were disciplined as a result of the incident as they restrained the resident inappropriately and did not follow the resident's bill of rights. The PSWs indicated that resident #004 was not treated with respect and dignity during the incident.

In an interview, agency RPN #117 indicated that resident #004 was physically restrained, which worsened the resident's responsive behaviour. RPN #117 stated that resident #004 was not treated with respect and dignity during the incident and the incident should have been managed differently.

In an interview, the DNC indicated that PSWs #110, #116 and #119 were disciplined and RN #101 would be disciplined as a result of the incident with resident #004. The DNC indicated that it is the home's expectation for all staff to follow the resident' bill of rights and the restraining of resident #004 by PSWs #110, #116 and #119, agency RPN #117 and RN #101 did not treat the resident with respect and dignity.

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 every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, is fully respected and promoted, to be implemented voluntarily.

WN #2: 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. (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).

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

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a CIS report to the MOHLTC for an incident that occurred on an identified date in 2018, related to staff to resident physical abuse. The CIS report indicated that resident #004 exhibited responsive behaviour and received an identified medication to manage the responsive behaviour. The report indicated that a total of five

staff were required to administer the medication.

A review of the resident #004's clinical records indicated that the resident exhibited responsive behaviour towards staff and other residents. The responsive behaviour plan of care at the time of the incident had two identified interventions (intervention A and B).

In interviews, PSWs #110 and #116 and agency RPN #117 indicated that RN #101 did not implement intervention A. RPN #117 indicated that they were the charge nurse on the day of the incident and did not implement intervention A prior to the medication administration. The PSWs and the RPN stated that the resident exhibited physical and verbally responsive behaviours towards the staff during the incident and intervention B was not implemented to assist in managing resident #004's responsive behaviours, as per plan of care.

In an interview, the DNC indicated that the plan of care is to be followed by all staff in the home. The DNC stated the home's investigation of the incident indicated that the three PSWs, RPN and RN involved in the incident did not follow the two identified interventions to manage the resident's responsive behaviour as per the plan of care. The DNC acknowledged that the plan of care for resident #004 was not followed as specified in the plan.

2. The licensee has failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

A review of the resident #004's clinical records indicated that the resident exhibited responsive behaviour towards staff and other residents. The responsive behaviour plan of care at the time of the incident had two identified interventions.

In an interview, agency RPN #117 indicated that they were the charge nurse for the unit on the day of the incident. The RPN stated that they have worked on the unit before and was aware that resident #004 exhibited responsive behaviours towards staff and other residents. The RPN indicated that on the day of the incident, they were supposed to have reviewed the plan of care for resident #004 but did not. The RPN stated they were not aware of the two identified interventions. If they would have known about the two interventions, RPN #117 stated that they would have managed the incident differently to help manage resident #004's responsive behaviour.

In an interview, the DNC indicated that direct care staff are to be aware of the contents of residents' plan of care and to review the written plan of care in PCC. The DNC acknowledged that agency RPN #117 did not follow the home's expectation of reviewing and being aware of the contents of the plan of care for resident #004.

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 care set out in the plan of care is provided to the resident as specified in the plan and that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure 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, was implemented.

In accordance to O.Reg.79/10, r. 53 (1) 1, Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: 1) Written approaches to care, including screening protocols, assessment,

reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

Specifically, the staff did not implement the licensee's policy, Tab04-84, titled, Personal Expression Program, last reviewed on January 30, 2018. The policy stated on page three under procedure that if a situation/incident occurs, the neighborhood team will initiate "The Personal Expressions Neighbourhood Observation Tool on point click care (PCC) prior to the end of their shift." The policy further indicated after the Personal Expression Neighbourhood Tool has been completed, the PERT Assessment on PCC will be initiated by the registered team member.

1) The home submitted a CIS report for an incident that occurred on an identified date in 2018, related to an allegation of resident to resident abuse. The CIS report indicated that resident #003 informed PSW #103 that they observed resident #002 touch resident #001 inappropriately.

A review of resident #002's plan of care indicated that the resident had a history of responsive behaviours towards staff and other residents. A review of resident #002's progress notes over a 20 day period indicated identified responsive behaviours towards resident #001. The progress notes indicated that the registered staff had spoken to resident #002 about their responsive behavior.

A review of the assessment tab in PCC and physical chart for resident #002 did not locate the completion of the Personal Expressions Neighbourhood Observation Tool and the PERT Assessment for the CIS incident noted above.

In an interview, RN #102 indicated that the responsive behaviours by resident #002 towards resident #001 was a new behaviour. The RN indicated that when a new behaviour occurs or when an incident occurs, a progress note is documented in PCC.

2) The home submitted a CIS report to the MOHLTC on an identified date in 2018, for resident to resident abuse. The CIS report indicated that PSW #120 witnessed resident #003 touch resident #001 inappropriately. PSW #120 observed resident #001 trying to remove the hands of resident #003 away.

A review of the assessment tab in PCC and physical chart of resident #003 did not locate the completion of the Personal Expressions Neighbourhood Observation Tool and the PERT Assessment for the CIS incident.

In an interview, RN #102 indicated that the home did not have an assessment tool at the time the two CIS reports occurred towards resident #001. When asked if the Personal Expressions Neighbourhood Observation Tool and the PERT Assessment were implemented in the home, the RN indicated the Tool and the PERT Assessment were not used in the home. RN #102 stated that the home had recently started to train the registered staff on the Personal Expressions Neighbourhood Observation Tool and the PERT Assessment over the past two months.

In an interview, the DNC indicated that at the time the two CIS incidents had occurred, the home was following their policy titled Personal Expression Program, last reviewed January 1, 2018. When asked if the Personal Expressions Neighbourhood Observation Tool and the PERT Assessment were implemented in the home at the time of the incidents, the DNC stated that they had just recently started to train the registered staff on the Tool and PERT Assessment. The DNC acknowledged that the home failed to ensure that their Personal Expression Program policy was implemented.

2. The licensee has failed to ensure 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, was complied with.

In accordance to O.Reg.79/10, s.114 (2), The licensee shall ensure that written polices and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home uses Medisystem Pharmacy's policies for their medication management system. The staff did not comply with the licensee's policy #MEDI-CL-ONT-042, titled, Narcotic and Controlled Substances Administration Record, with an effective date of October 1, 2018. Under procedure number eight, it indicated that "A count of all narcotics is to be made on the Narcotic and Controlled Substance Administration Record. A check of the balance-on-hand must be completed by two nurses or care providers at the time of every shift change. The count and each signature are recorded in the appropriate column on the Narcotic and Controlled Substance Administration Record."

During observations on an identified resident home area (RHA) on January 29, 2018, at 1350 hours (hrs), NS #115 was observed sitting in the nursing station with narcotics and controlled substances and was observed to have signed the outgoing column of a

resident's narcotic and controlled drug administration record.

In an interview, NS #115 indicated that they were counting the narcotics to ensure the count was correct and confirmed that they had signed the outgoing column of the narcotic and controlled drug administration records.

In an interview, RN #102 indicated that NS #115 was checking to make sure the narcotic counts were correct and the outgoing column of the narcotic and controlled drug administration records were signed by NS #115 prior to the change of shift narcotic count.

In an interview, ADOC #111 indicated that it is the home's policy for narcotic counts to be completed by two registered staff at the change of shift and signed together by the registered staff at the time of the count, not prior. The ADOC acknowledged that NS #115 and RN #102 failed to follow the home's policy on narcotic and controlled substances administration record related to narcotic counts.

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 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 (b) is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to ensure that residents were protected from abuse by anyone.

The home submitted a CIS report to the MOHLTC on an identified date in 2018, for resident to resident abuse. The CIS report indicated that PSW #120 witnessed resident #003 touch resident #001 inappropriately while the resident was sitting in an identified common area on a specified RHA. PSW #120 observed resident #001 trying to remove the hands of resident #003 away. As per the CIS report, PSW #120 reported the incident to RPN #104, who went into the identified common area and observed resident #003 to have exhibited an inappropriate behaviour towards resident #001, and observed resident #001 try to move resident #003's hands away. The RPN spoke to resident #003 about their inappropriate behaviour, resident #003 apologized and returned to their own RHA.

A review of resident #003's written plan of care at the time of the incident did not indicate the resident had a history of responsive behaviour towards other residents.

In interviews, RPN #104, RN #102 and PSW #103 indicated that resident #003 was cognitively aware at the time of the incident.

A review of the home's investigation notes indicated that resident #003 denied the allegation of abuse towards resident #001. The home interviewed resident #001 who indicated that they recalled sitting in the identified common area with another resident of the opposite gender. When the home asked resident #001 if they recalled the other resident wanting to engage in an identified activity, resident #001 indicated they remembered something but was not able to recall further. Further review of the investigation notes indicated RPN #104 had informed the DNC immediately of the incident. PSW #120 indicated to the DNC that they had observed resident #003 touch resident #001 inappropriately in the identified common area and informed RPN #104 immediately.

A review of resident #003's progress notes on an identified date, indicated that PSW

#120 saw resident #003 very close to resident #001 and observed resident #003 touch resident #001 inappropriately, and resident #001 was trying to remove resident #003's hand away. PSW #120 did not confront resident #003, and immediately informed the charge nurse.

Attempts to contact PSW #120 were unsuccessful.

In an interview, RPN #104 indicated the incident was considered to be abuse towards resident #001 by resident #003. The RPN stated that the identified PSW witnessed resident #001 trying to remove resident #003's hand away and did not consent to being touched inappropriately by resident #003. RPN #104 further indicated that resident #001 would use body language when they did not like something or not wanting to be touched.

In interviews, PSWs #100 and #103 indicated that resident #001 was able to communicate to staff and other residents when they did not like or want something. The PSWs indicated that resident #001 would use body language when they did not want or like something.

In an interview, resident #001 indicated that another resident had touched them inappropriately. When asked what they would do if someone tried to touch them inappropriately, resident #001 indicated they would go away.

In an interview, the DNC indicated that the home conducted an investigation and was able to confirm the allegation of abuse towards resident #001 by resident #003. The DNC stated that the incident was witnessed by PSW #120 and acknowledged that the home did not protect resident #001 from abuse by resident #003.

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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #5: 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 :

The licensee has failed to ensure that 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: 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.

The home submitted a CIS report to the MOHLTC on an identified date in 2018, related to an allegation of resident to resident abuse.

A review of the CIS report indicated that it was submitted by the DNC to the MOHLTC seven days after the alleged incident occurred.

In an interview, the DNC indicated that it is the home's abuse policy for any allegation, suspected or actual abuse to be reported to the MOHLTC immediately. When asked when they were made aware of the allegation of abuse, the DNC indicated they were made aware four days after the alleged incident. The DNC indicated the home had failed to report the allegation of abuse immediately to the Director.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone 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, to be implemented voluntarily.

WN #6: 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 :

The licensee has failed to 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: 4) How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and regulations.

The home submitted a CIS report to the MOHLTC for an incident that occurred on an identified date in 2018, related to staff to resident physical abuse.

A record review of the investigation notes indicated that resident #004 was physically restrained by PSWs #110, #116 and #119.

A review of the home's 2018 education records for minimizing restraints indicated that four PSWs did not receive their annual minimizing restraint training, which included PSWs #110 and #116, who were involved in the CIS incident noted above.

In an interview, the GM acknowledged PSWs #110 and #116 were direct care staff and the PSWs should have received training on minimizing restraints for 2018. The GM acknowledged the home failed to ensure that all staff who provide direct care to resident received training on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and regulations.

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 provide direct care to resident receive, as a condition of continuing to have contact with resident, training on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and regulations, at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

The licensee has failed to ensure that for the purposes of section 35 of the Act, the the following devices are not used in the home: 7) Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose were not used in the home.

The home submitted a CIS report to the MOHLTC for an incident that occurred on an identified date in 2018, related to staff to resident physical abuse. The CIS report indicated that resident #004 exhibited responsive behaviour and received an identified medication to manage their responsive behaviour. The report indicated that a total of five staff were required to administer the medication.

A record review of the home's investigation notes indicated that resident #004 was physically restrained by three PSWs and an agency RPN during the incident. A further review of the investigation notes indicated that PSW #119 used an identified device to further prevent the resident from moving during the medication administration.

In interviews, PSW #116 and agency RPN #117 stated that the identified device was used on resident #004 to prevent them from moving during the administration of the medication. The PSW and RPN indicated that the identified device was a prohibited restraining device and should not have been used on resident #004.

In an interview, the DNC indicated that PSWs #110 and #116 and PSW #119 were disciplined and RN #101 would be disciplined as a result of the incident with resident #004. The DNC stated that the identified device was used to restrain resident #004 which was a prohibited restraining device and did not have any therapeutic purpose.

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 following devices are not used in the home: Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that their written policy to minimize the restraining of residents was complied with.

Specifically, the staff did not comply with the licensee's policy, Tab04-52, titled Restraint and Personal Assistance Services Device (PASD) Procedures in LTC, last reviewed on June 1, 2017. On page eight, the policy outlined procedures for PASD use. The policy indicated that the Alternatives to Restraint/PASD Assessment must be completed prior to using a PASD and quarterly thereafter. The completed assessment will be placed in the quarterly review section of the resident's chart or updated in the current computerized software system by the registered team member.

The minimizing restraint inspection protocol (IP) was initiated for resident #005 to expand the sample as a result of findings of non-compliance for resident #004.

A review of resident #005's plan of care indicated that the resident had an identified device as a PASD since an identified date in 2018. A review of the assessment tab in PCC did not locate any Alternatives to Restraint/PASD Assessments prior to initiating the PASD and quarterly.

In interviews, RN #113 and RPN #114 indicated that the Alternatives to Restraint/PASD Assessments are to be completed prior to PASD use and quarterly as per the home's policy.

In an interview, the DNC indicated that it is the home's policy for the Alternatives to Restraint/PASD Assessments be completed prior to PASD use and quarterly. The DNC reviewed the assessment tab in PCC and indicated that the assessment was not completed prior to the PASD use and quarterly thereafter as per the home's policy for resident #005.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD 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. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker (SDM) of the resident with authority to give that consent.

The minimizing restraint IP was initiated for resident #006 to expand the sample as a result of findings of non-compliance for resident #004.

A review of resident #006's current plan of care indicated the use of an identified PASD for the past 10 months. Further review of the physical chart and the progress notes in PCC did not locate consent from the SDM for the use of the PASD.

In interviews, RN #113 and RPN #114 indicated that it is the home's process for consent to be received from the resident or the SDM if a resident has a PASD. RPN #114 reviewed the progress notes in PCC and reviewed resident #006's physical chart and acknowledged that they could not locate a verbal or written consent for the PASD.

In an interview, the DNC reviewed the progress notes and the physical chart and could not locate that a consent was provided for resident #006's PASD use.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

The licensee has failed to ensure that at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A documentation review of the home's annual evaluation of their responsive behavior program did not locate the home's 2017 program evaluation.

In an interview, the GM indicated that the home did not conduct the annual program evaluation of their responsive behavior program in 2017. The GM stated they have put in place a schedule to ensure that program evaluations were conducted annually and that the 2018 responsive behaviour program evaluation was scheduled for September 2019.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

The licensee has failed to ensure that a written record was created and maintained for each resident of the home.

The home submitted a CIS report on for an allegation of abuse towards resident #001 by resident #002 on an identified date in 2018.

A review of resident #001's plan of care indicated that they exhibited an identified responsive behaviour. The plan of care directed staff to document an identified intervention on a specified checklist.

In interviews, PSW #103 and #105, RPN #104 and RN #102 indicated that prior to the home upgrading their PCC software, the identified intervention for resident #001 was documented on a specified checklist form attached to a clipboard. RPN #104 and RN #102 indicated once the completed checklist was completed, it was filed in the resident's chart.

A review of resident #001's physical chart with RPN #104 including thinned documentation, did not locate the specified checklist documentation for resident #001.

In an interview, the DNC indicated that the identified intervention for resident #001 was documented on paper on a specified checklist, at the time of the CIS incident. The DNC stated that the completed specified checklist would have been filed in resident #001's chart; however, was unable to locate the checklist documentation in the home. The home failed to ensure that resident #001's written record was maintained.

Issued on this 12th day of February, 2019

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

Original report signed by the inspector.