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 # / Registre no	Type of Inspection / Genre d'inspection
Jul 7, 2016	2016_280541_0017	010644-16/010394-16	Complaint

Licensee/Titulaire de permis

COUNTY OF PRINCE EDWARD
603 Highway 49 R R 2 PICTON ON K0K 2T0

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

H.J. MCFARLAND MEMORIAL HOME
R.R. #2, 603 HIGHWAY 49 HALLOWELL TOWNSHIP PICTON ON K0K 2T0

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

AMBER MOASE (541)

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): June 17, 21-22, 24, 27-30, 2016

This inspection was for one complaint and two associated Critical Incidents regarding concerns related to resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care (DOC), Registered Nurses, the home's Physiotherapist, a Physiotherapy Assistant, Registered Practical Nurses, Personal Support Workers, a family member and residents. In addition, the inspector observed residents at various times throughout the day, reviewed resident health care records and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **2 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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

The licensee has failed to ensure that if a resident is being restrained by a physical

device, (a) the device is used in accordance with any requirements provided for in the regulations.

Resident #001 is identified as a high risk of falls related to an unstable health condition.. On a specified date, resident #001 fell and sustained an injury.

As per O.Reg 79/10 s. 110(1) every licensee shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. The physical device is applied in accordance with any manufacturer's instructions.

On a specified date and time, this inspector observed resident #001 seated in the resident's wheelchair with a rear-closing restraint applied. The seat-belt was noted to be very loose such that inspector could fit an entire arm between the resident and the restraint and the belt could be easily moved up to the resident's neck.

On a specified date and time, inspector observed resident #002 seated in the resident's wheelchair with a rear-closing seat belt restraint applied. This seat-belt was also noted to be very loose such that it could easily be raised to the upper waist/chest of resident #002.

This inspector immediately asked the physiotherapy assistant (PTA) #103 and the physiotherapist #102 to observe resident #001 and #002's seat belts. PTA #103 and physiotherapist #102 both confirmed that both seat belts were too loose and confirmed with inspector that they are aware the seat belts need to be fixed. They further stated there would be somebody coming into the home today to do so. PTA #103 attempted to tighten both seat belts but inspector observed afterwards they were unable to be tightened.

Later in the day on the same specified date, this inspector observed resident #001 in the resident's room seated in a wheel-chair with the rear-closing seat belt applied. The seat-belt was positioned at the high waist area of the resident and could easily be moved up to the resident's neck. Inspector asked RPN #104 to observe resident #001's seat belt. Inspector showed RPN #104 how the seat belt can be lifted up to the resident's neck and RPN #104 agreed that it is too loose and that the belt is supposed to be applied around the stomach area and be tight. RPN #104 further stated that it would be better to remove the rear-closing seat belt as it does not fit properly at this time. RPN #104 however did not tighten nor remove the loosely applied seat belt and left resident #001 in the

wheelchair in the resident's room with the loose rear-closing seat belt applied. PTA #103 then entered resident #001's room and saw the loose fitting rear-closing seat-belt and again confirmed that it is loose but was unsure what else could be done.

Approximately an hour later on the same specified day, physiotherapist #102 approached this inspector and stated that the company who repairs seat belts informed him/her that the rear-closing seat-belts cannot be adjusted and there is nothing further the company can do with them. Physiotherapist #102 further stated the home is now exploring other options to keep the resident's safe and will discuss these options with the appropriate resident or family.

Resident #002 was again observed later on the same specified date. Resident #002's rear-closing seat belt was again loosely applied and could easily be moved above the resident's chest area.

On the same specified date, inspector informed the home's Director of Care (DOC) about the rear-closing seat belts and the DOC was unaware the home was using rear-closing seat-belts and states they should not be applied so loose.

The following day, this inspector was informed that the home has removed all rear-closing seat belts and replaced them with front-closing belts and a personal clip alarm.

Inspector #541 was provided a document titled "Seat Belts – How to Put on a Seat Belt Guidelines." This document was developed by the home's corporate physiotherapist and was used as staff education. The document states the following related to seat belt application:
- Apply the belt snugly around the pelvis
- When pulled snugly there should only be one finger breadth of space between the belt and the pelvis
- Frequently check the placement and fit of the seat belt to ensure it remains in the correct place

Inspector #541 requested the manufacturer's instructions for rear-closing seat-belts from physiotherapist #104 and was informed there are no manufacturer's instructions.

On a specified date three days later, inspector observed resident #001 who was seated in a wheelchair in the resident's room. Resident #001 had a front closing seat belt applied and was loose enough that it could be pulled away from the resident such that an

entire arm fit under the belt. When this inspector asked resident #001 if he/she could undo the seat-belt resident #001 stated he/she could but when asked to demonstrate this to the inspector, resident #001 was unable to undo the front-closing seat-belt.

Inspector #541 interviewed PSW staff #105 who stated that the belt appears loose and further stated the PSWs do not have the authority to fix it, instead they are to inform the registered staff. PSW #105 left the room and did not inform a registered staff member about resident #001's loosely applied seat belt. Inspector #541 immediately went to inform RPN #106 who confirmed he/she was not informed of the loose fitting seat belt by a PSW.

Inspector #541 asked RPN #106 to observe resident #001's seat belt. RPN #106 confirmed the seat-belt is too loose and also confirmed if a PSW observes this they are to inform the registered staff. At the time of this observation PTA #103 was attempting to fix resident #001's seat belt and confirmed it was loose. A few moments later, PTA #103 confirmed the seat-belt was able to be tightened.

The home failed to apply a seat-belt restraint for resident #001 and resident #002 in accordance with the manufacturer's instructions.

As per O. Reg 79/10 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.

Resident #001 and #002 were observed on a specified date with rear-closing seat belt restraints and on another specified date resident #001 was observed with a with front-closing seat belt. When asked if he/she can undo the seat-belt resident #001 stated he/she could but when asked to demonstrate this to inspector #541, resident #001 was unable to undo the front-closing seat-belt.

Inspector #541 confirmed with PSW #107 and 108 that documentation for restraints is done using the Point of Care (POC) electronic system. Inspector #541 printed the POC for residents #001 and #002.

The POC documentation for resident #001 and #002 reflects the use of a seat-belt restraint. There is no space on the POC documentation for staff to indicate resident #001 and #002 were released from their restrain and repositioned every 2 hours.

PSW #107 and #108 both confirmed that there is nowhere for staff to document the release and repositioning from a restraint every 2 hours.

As per O. Reg 79/10 s. 109(g) Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with, (g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

During the inspection, this inspector requested the home's policy(ies) regarding the use of restraints. This inspector was directed to speak with RN #104 who is identified as the Chair of the home's restraint program. RN #104 provided this inspector with policy #VII-E-10.00 titled "Restraint Implementation Protocols" and confirmed this is the policy currently in use at the home.

On the policy, there are handwritten, undated updates which state:
- Bringing Tracking Tool
- Need an audit tool
- Document monthly on assessment on the need for continuing the restraint

The policy does not address how the use of restraining will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and Regulation. [s. 31. (3) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that there are written procedures that comply with

the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

On two specified dates, the home notified the Director that they had received written concerns regarding the care of resident #001. The letter outlined concerns that staff were not complying with resident #001's plan of care related to falls and therefore resident #001 was at risk of harm. The letter outlining the concerns was forwarded to the Director.

As per O. Reg 79/10 101 (1) the licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

At the start of this inspection, Inspector #541 requested all of the home's documentation related to concerns brought forward related to resident #001. Inspector #541 was provided with a file which contained four separate communications (written letter and email) sent to the home in regards to resident #001's care. The home received the concerns on four specified dates.

The home was unable to provide any evidence that the concerns brought forward regarding the care of resident #001 were investigated.

Upon review of the documentation provided to Inspector #541, it was noted there are three response letters provided to the complainant. The first response letter from the home to the complainant was not dated and therefore inspector was unable to determine to which concern this was a response to. The second response letter was dated for a specified date and it was also unclear to which this concern this was a response to. The last response was provided via email on a specified date and was in response to a complaint made five days earlier

Inspector #541 was unable to find any associated responses to the complaint letters provided to the home on the three other specified dates.

On two specified dates, the home notified the Director that they had received written

concerns regarding the care of resident #001; the letter outlining the concerns was forwarded to the Director.

Inspector #541 requested the home's complaint log. Inspector was provided with a binder which was reviewed. The home's complaint binder does not contain a record of any complaints received since early January, 2016.

As per O. Reg 79/10 101 (2) the licensee shall ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

At the start of this inspection, Inspector #541 requested all of the home's documentation related to concerns brought forward related to resident #001. Inspector #541 was provided with a file which contained four separate communications (written letter and email) sent to the home in regards to resident #001's care pn four specified dates in 2016. There is no record of the complaints in the home's complaint binder.

As per O. Reg 79/10 s. 100 the licensee shall ensure that there are written complaint procedures in place that incorporate the requirements set out in section 101 for dealing with complaints.

Inspector #541 requested the home's complaint policy from the Administrator. Inspector was provided with policy #ADM-I-101 titled Complaints, Concerns and Suggestion Policy. This inspector confirmed with the Administrator that this is the current complaint policy for the home.

The home's policy # ADM-I-101 was reviewed. The policy does not reflect the following as required per O. Reg. 79/10 s. 101:
- The complaint shall be investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately
- For the complaint that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days

of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances
- A response shall be made to the person who made the complaint, indicating what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief.

Inspector #541 reviewed policy # ADM-I-101 with the home's Administrator who confirmed the policy does not contain the required information. [s. 21.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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).

Findings/Faits saillants :

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

Resident #001 is identified as a high risk of falls related to an unstable health condition. On a specified date, resident #001 fell and sustained an injury.

Resident #001's current plan of care, effective during the specified dates below was reviewed and it indicates specific fall prevention interventions which are to be in place.

On a specified date, it was documented that resident #001 was assisted to the bathroom and one of the specified fall interventions was not followed.

On a specified it was documented the family of resident #001 discovered resident to be in bed without two of the specified fall interventions in place. Inspector #541 confirmed with the witnessing staff member RN #101 that this did in fact occur. RN #101 informed inspector that upon investigating, it was discovered that resident #001 had walked back upstairs without supervision following the dinner meal and put him/her-self to bed.

On a specified date it was documented that the family of resident #001 observed the resident to be left alone in the bathroom. Upon investigating, the home identified the staff member assisting resident #001 was not aware the resident was not to be left alone in the bathroom.

During the inspection, this inspector observed resident #001 seated in his/her wheelchair in the resident's room with his/her seat belt applied. Resident #001 has a specified fall prevention intervention in place while seated in his/her wheelchair and this intervention was not in place.

RN #109 confirmed with Inspector #541 that resident #001 was to have the specified fall intervention in place.

Resident #001 did not have care provided as specified in his/her plan of care. [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 to ensure the care set out in resident #001's plan of care related to falls and transferring, is provided as specified in the plan, to be implemented voluntarily.

Issued on this 8th day of July, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMBER MOASE (541)
Inspection No. / No de l'inspection :	2016_280541_0017
Log No. / Registre no:	010644-16/010394-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 7, 2016
Licensee / Titulaire de permis :	COUNTY OF PRINCE EDWARD 603 Highway 49, R R 2, PICTON, ON, K0K-2T0
LTC Home / Foyer de SLD :	H.J. MCFARLAND MEMORIAL HOME R.R. #2, 603 HIGHWAY 49, HALLOWELL TOWNSHIP, PICTON, ON, K0K-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pamela Nisbet

To COUNTY OF PRINCE EDWARD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations;
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations;
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations;
(d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations;
(e) the resident is restrained only for as long as is necessary to address the risk referred to in paragraph 1 of subsection (2);
(f) the method of restraining used is discontinued if, as a result of the reassessment of the resident's condition, one of the following is identified that would address the risk referred to in paragraph 1 of subsection (2):
(i) an alternative to restraining, or
(ii) a less restrictive method of restraining that would be reasonable, in light of the resident's physical and mental condition and personal history; and
(g) any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 31 (3).

Order / Ordre :

The licensee shall ensure that, if a resident is being restrained by a physical device:

1. the device is applied in accordance with any manufacturer's instructions as per O.Reg 79/10, section 110(1);
2. every release of the device and all repositioning are documented as per O.Reg. 79/10, section 110 (7);
3. the resident is monitored while restrained by a member of the registered nursing staff at least every hour, and more often based on the resident's needs, to ascertain that the device is correctly applied; and
4. the home's written policy to minimize the restraining of residents addresses how the use of restraining will be evaluated in accordance with Reg. 79/10, section 109 (g).

Grounds / Motifs :

1. The licensee has failed to ensure that if a resident is being restrained by a physical device, (a) the device is used in accordance with any requirements provided for in the regulations.

Resident #001 is identified as a high risk of falls related to an unstable health condition. On a specified date, resident #001 fell and sustained an injury.

As per O.Reg 79/10 s. 110(1) every licensee shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. The physical device is applied in accordance with any manufacturer's instructions.

On a specified date and time, this inspector observed resident #001 seated in the resident's wheelchair with a rear-closing restraint applied. The seat-belt was noted to be very loose such that inspector could fit an entire arm between the resident and the restraint and the belt could be easily moved up to the resident's neck.

On a specified date and time, inspector observed resident #002 seated in the resident's wheelchair with a rear-closing seat belt restraint applied. This seat-belt was also noted to be very loose such that it could easily be raised to the upper waist/chest of resident #002.

This inspector immediately asked the physiotherapy assistant (PTA) #103 and

the physiotherapist #102 to observe resident #001 and #002's seat belts. PTA #103 and physiotherapist #102 both confirmed that both seat belts were too loose and confirmed with inspector that they are aware the seat belts need to be fixed. They further stated there would be somebody coming into the home today to do so. PTA #103 attempted to tighten both seat belts but inspector observed afterwards they were unable to be tightened.

Later in the day on the same specified date, this inspector observed resident #001 in the resident's room seated in a wheel-chair with the rear-closing seat belt applied. The seat-belt was positioned at the high waist area of the resident and could easily be moved up to the resident's neck. Inspector asked RPN #104 to observe resident #001's seat belt. Inspector showed RPN #104 how the seat belt can be lifted up to the resident's neck and RPN #104 agreed that it is too loose and that the belt is supposed to be applied around the stomach area and be tight. RPN #104 further stated that it would be better to remove the rear-closing seat belt as it does not fit properly at this time. RPN #104 however did not tighten nor remove the loosely applied seat belt and left resident #001 in the wheelchair in the resident's room with the loose rear-closing seat belt applied. PTA #103 then entered resident #001's room and saw the loose fitting rear-closing seat-belt and again confirmed that it is loose but was unsure what else could be done.

Approximately an hour later on the same specified day, physiotherapist #102 approached this inspector and stated that the company who repairs seat belts informed him/her that the rear-closing seat-belts cannot be adjusted and there is nothing further the company can do with them. Physiotherapist #102 further stated the home is now exploring other options to keep the resident's safe and will discuss these options with the appropriate resident or family.

Resident #002 was again observed later on the same specified date. Resident #002's rear-closing seat belt was again loosely applied and could easily be moved above the resident's chest area.

On the same specified date, inspector informed the home's Director of Care (DOC) about the rear-closing seat belts and the DOC was unaware the home was using rear-closing seat-belts and states they should not be applied so loose.

The following day, this inspector was informed that the home has removed all

rear-closing seat belts and replaced them with front-closing belts and a personal clip alarm.

Inspector #541 was provided a document titled "Seat Belts – How to Put on a Seat Belt Guidelines." This document was developed by the home's corporate physiotherapist and was used as staff education. The document states the following related to seat belt application:
- Apply the belt snugly around the pelvis
- When pulled snugly there should only be one finger breadth of space between the belt and the pelvis
- Frequently check the placement and fit of the seat belt to ensure it remains in the correct place

Inspector #541 requested the manufacturer's instructions for rear-closing seat-belts from physiotherapist #104 and was informed there are no manufacturer's instructions.

On a specified date three days later, inspector observed resident #001 who was seated in a wheelchair in the resident's room. Resident #001 had a front closing seat belt applied and was loose enough that it could be pulled away from the resident such that an entire arm fit under the belt. When this inspector asked resident #001 if he/she could undo the seat-belt resident #001 stated he/she could but when asked to demonstrate this to the inspector, resident #001 was unable to undo the front-closing seat-belt.

Inspector #541 interviewed PSW staff #105 who stated that the belt appears loose and further stated the PSWs do not have the authority to fix it, instead they are to inform the registered staff. PSW #105 left the room and did not inform a registered staff member about resident #001's loosely applied seat belt. Inspector #541 immediately went to inform RPN #106 who confirmed he/she was not informed of the loose fitting seat belt by a PSW.

Inspector #541 asked RPN #106 to observe resident #001's seat belt. RPN #106 confirmed the seat-belt is too loose and also confirmed if a PSW observes this they are to inform the registered staff. At the time of this observation PTA #103 was attempting to fix resident #001's seat belt and confirmed it was loose. A few moments later, PTA #103 confirmed the seat-belt was able to be tightened.

The home failed to apply a seat-belt restraint for resident #001 and resident #002 in accordance with the manufacturer's instructions.

As per O. Reg 79/10 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.

Resident #001 and #002 were observed on a specified date with rear-closing seat belt restraints and on another specified date resident #001 was observed with a with front-closing seat belt. When asked if he/she can undo the seat-belt resident #001 stated he/she could but when asked to demonstrate this to inspector #541, resident #001 was unable to undo the front-closing seat-belt.

Inspector #541 confirmed with PSW #107 and 108 that documentation for restraints is done using the Point of Care (POC) electronic system. Inspector #541 printed the POC for residents #001 and #002.

The POC documentation for resident #001 and #002 reflects the use of a seat-belt restraint. There is no space on the POC documentation for staff to indicate resident #001 and #002 were released from their restrain and repositioned every 2 hours.
PSW #107 and #108 both confirmed that there is nowhere for staff to document the release and repositioning from a restraint every 2 hours.

As per O. Reg 79/10 s. 109(g) Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with, (g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

During the inspection, this inspector requested the home's policy(ies) regarding the use of restraints. This inspector was directed to speak with RN #104 who is identified as the Chair of the home's restraint program. RN #104 provided this inspector with policy #VII-E-10.00 titled "Restraint Implementation Protocols" and confirmed this is the policy currently in use at the home.

On the policy, there are handwritten, undated updates which state:

- Bringing Tracking Tool
- Need an audit tool
- Document monthly on assessment on the need for continuing the restraint

The policy does not address how the use of restraining will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and Regulation. [s. 31. (3) (a)]
The decision to leave a Compliance Order was based on the following:
- A Compliance Order for O. Reg. 79/10 s. 110(1)1 was issued November, 2015 for resident #001 (Inspection # 2015_396103_0053)
- Resident #001 and #002 were restrained inappropriately putting them at risk of harm. A loose fitting seat belt poses a risk of strangulation to the resident.
- There was no documentation to reflect that resident #001 and resident #002 were being released from their restraint and repositioned.
- The home's policy does not address how the use of restraining will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and Regulation. (541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Order / Ordre :

The licensee shall ensure:

- that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. (As per O. Reg 79/10 s.101 (1))

- that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant. (O. Reg 79/10 s.101 (2))

- that policy #ADM-I-101 titled Complaints, Concerns and Suggestion is updated to reflect the requirements as per O. Reg. 79/10 s. 101 and that it is complied with. (O. Reg 79/10 s.100)

Grounds / Motifs :

1. 1. The licensee has failed to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

On two specified dates, the home notified the Director that they had received written concerns regarding the care of resident #001. The letter outlined concerns that staff were not complying with resident #001's plan of care related to falls and therefore resident #001 was at risk of harm. The letter outlining the concerns was forwarded to the Director.

As per O. Reg 79/10 101 (1) the licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

At the start of this inspection, Inspector #541 requested all of the home's documentation related to concerns brought forward related to resident #001. Inspector #541 was provided with a file which contained four separate communications (written letter and email) sent to the home in regards to resident #001's care. The home received the concerns on four specified dates.

The home was unable to provide any evidence that the concerns brought forward regarding the care of resident #001 were investigated.

Upon review of the documentation provided to Inspector #541, it was noted there are three response letters provided to the complainant. The first response letter from the home to the complainant was not dated and therefore inspector was unable to determine to which concern this was a response to. The second response letter was dated for a specified date and it was also unclear to which this concern this was a response to. The last response was provided via email on a specified date and was in response to a complaint made five days earlier

Inspector #541 was unable to find any associated responses to the complaint letters provided to the home on the three other specified dates.

On two specified dates, the home notified the Director that they had received written concerns regarding the care of resident #001; the letter outlining the concerns was forwarded to the Director.

Inspector #541 requested the home's complaint log. Inspector was provided with a binder which was reviewed. The home's complaint binder does not contain a record of any complaints received since early January, 2016.

As per O. Reg 79/10 101 (2) the licensee shall ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

At the start of this inspection, Inspector #541 requested all of the home's documentation related to concerns brought forward related to resident #001. Inspector #541 was provided with a file which contained four separate communications (written letter and email) sent to the home in regards to resident #001's care pn four specified dates in 2016. There is no record of the complaints in the home's complaint binder.

As per O. Reg 79/10 s. 100 the licensee shall ensure that there are written complaint procedures in place that incorporate the requirements set out in section 101 for dealing with complaints.

Inspector #541 requested the home's complaint policy from the Administrator. Inspector was provided with policy #ADM-I-101 titled Complaints, Concerns and Suggestion Policy. This inspector confirmed with the Administrator that this is the current complaint policy for the home.

The home's policy # ADM-I-101 was reviewed. The policy does not reflect the following as required per O. Reg. 79/10 s. 101:
- The complaint shall be investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately
- For the complaint that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that

complies with paragraph 3 shall be provided as soon as possible in the circumstances
- A response shall be made to the person who made the complaint, indicating what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief.

Inspector #541 reviewed policy # ADM-I-101 with the home's Administrator who confirmed the policy does not contain the required information. [s. 21.]

The decision to issue a Compliance Order was based on the following:
- In December 2015 a non-compliance for was identified for O.Reg 79/10 s.101(1)2 and 3 for failing to provide an acknowledgement of receipt of the complaint within 10 days and for failing to respond to the complaint indicating what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief (Inspection #2015_330573_0030). A Voluntary Plan of Correction (VPC) was issued at that time.
- In March 2016 a non-compliance was again issued for O.Reg 79/10 s. 101(1)3 for failing to provide a response to the person who made the complaint indicating what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief (Inspection # 2016_236622_0010). A Written Notification (WN) was issued at that time.
- The home does not currently keep a documented record of complaints received regarding the care of a resident or operation of the home
- The home has failed to immediately investigated concerns brought forward regarding the care of resident #001 that alleged risk of harm.
- The home's policy for dealing with complaints does not reflect the requirements as per O. Reg. 79/10 s. 101
(541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7th day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amber Moase

Service Area Office /
Bureau régional de services : Ottawa Service Area Office