Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: October 18, 2024
Inspection Number: 2024-1258-0003
Inspection Type: Critical Incident
Licensee: Shanti Enterprises Limited
Long Term Care Home and City: Royal Terrace, Palmerston

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 11 - 12, 19 - 20, and 23 - 27, 2024

The following intakes were inspected:

- Intakes 00115510 and 00122246 - Related to residents' falls.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to document a safety check falls prevention intervention for a resident.

Rationale and Summary
A resident had a falls prevention intervention of safety checks by staff at certain time intervals.

At the time of inspection, staff reported the checks were not documented.

By not documenting the intervention provided to the resident, as well as the resident's responses to the intervention, the intervention's effectiveness could not be evaluated. Additionally, the resident was at increased risk of inconsistent care.

Sources: Interviews with personal support worker (PSW) staff, and the home's Director of Care (DOC); A resident's clinical records including their plan of care, task list; Inspector observations.

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure a resident received immediate interventions to promote healing and prevent infection when they were identified to have a new wound.

Rationale and Summary
A resident was identified to have a new wound by registered staff. The wound was not immediately assessed with the home's clinically appropriate tool, and a task for registered staff to apply daily treatment was not initiated until several days later.

When the resident did not receive receive immediate interventions to promote healing and prevent infection of their new wound, they were at increased risk of inappropriate assessment and intervention.

Sources: Interview the home's DOC and other staff; A resident's clinical records, and a critical incident report.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure a resident's wound was reassessed at least weekly by authorized staff.

Rationale and Summary
A resident's wound was not reassessed weekly for a period of weeks. It was not resolved at the time of inspection.

When the wound was not reassessed at least weekly, the resident was at increased risk of unidentified changes and ineffective wound care.

Sources: Interview with the home's DOC; A resident's clinical records

COMPLIANCE ORDER CO #001 Policy to minimize restraining of residents, etc.

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 33
Policy to minimize restraining of residents, etc.
s. 33.
(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
(b) shall ensure that the policy is complied with.
(2) The policy must comply with such requirements as may be provided for in the regulations.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Review and revise the home's written policies to minimize restraining of residents as necessary, to ensure when and if residents are physically restrained, it is done in accordance with the Fixing Long Term Care Act and Ontario Regulation 246/22.

Maintain a record of the revision process, including:

i) Meeting dates, times, and notes on discussions held.

ii) Meeting participants and their designation(s).

iii) An outline of all relevant legislation and how it will be captured in the policy.

iv) The outcome of the revision, and date of implementation for the revised policy.

2. Create a process to ensure that when physical restraints are discontinued, it is done in a safe manner. The process should involve:

a) Consultation with the interdisciplinary team, including the physician

b) A process for monitoring the resident after the restraint removal for concerns

c) Documentation of processes described in 5 a) and b)

d) Maintain a record of the interdisciplinary consultation, including date(s), contents of discussion(s), as well as a record of the finalized process, and date of implementation.

3. Educate all personal support worker and registered staff on the relevant associated policy revisions. A record will be maintained of the education provided, who received the education, date(s) of when the education was provided, as well as the contents of the education and training materials.

4. Educate non-nursing staff who perform direct care role(s) on the relevant associated policy revision(s) regarding which staff have the authority to apply, modify, and release residents' physical restraints. A record will be maintained of the education provided, who received the education, date(s) of when the education was provided, as well as the contents of the education and training materials.

5. Following the policy revision and implementation, as well as staff education, conduct an audit of restraining care and documentation for all residents in October 2024 with restraints in their plan of care.

a) The audit will review the following for all residents with restraints to ensure all areas are completed as per the revised policy:

i) Identifying, trialing, and evaluating alternatives to physical restraining, both before implementing restraints, and during restraint use

ii) Orders for restraint use provide clear direction to staff, including use and type of restraint

iii) Consent forms are completed

iv) Interventions and evaluations are documented for a two week period

v) Whether the restraints had been altered

b) The audit will be conducted by a member of the home's management, or clinical leadership team.

c) Maintain a record of the audits completed, dates of when the audits were completed, names of the residents reviewed in the audit, and who completed the audits.

d) Maintain a record of any action taken when non-compliance is identified, including the dates the corrective actions were taken, and who was responsible for taking the remedial action.

e) Analyze the results of the audits, address any concerns identified, and document the corrective actions taken. Maintain a record of the date of analysis, and who completed it.

Grounds

The licensee failed to ensure the home's policy to minimize restraining of residents, as well as any physical restraining done of residents at the home, were both compliant with the requirements of the Fixing Long Term Care Act and Ontario Regulation 246/22.

A resident at the home was injured, and their physical restraints were identified as a contributing factor.

At the time of inspection, multiple residents at the home had physical restraints in their respective plans of care. After concerns with physical restraint use were identified, the Administrator reported the home was considering removing all restraints from the facility following the inspection. The home's Restraints policy did not outline a process to ensure the safe removal of restraints.

Concerns identified with restraining included the following:

1) The licensee failed to ensure the home's policy to minimize use of restraining of residents complied with requirements provided for in the Regulation.

Specifically, the home did not have a process in their policy to ensure they were compliant with Ontario Regulation 246/22 s. 118(b)(i), s. 118(b)(ii), s. 118 (e), s. 118 (f), and s. 118 (g).

A) The licensee failed to ensure the home's written policy to minimize restraining of residents included duties and responsibilities of staff, including who had the authority to apply a physical device to restrain a resident, or release a resident, from a physical device, as outlined in Ontario Regulation 246/22 s. 118 (b)(i).

Rationale and Summary
The home's Restraints policy did not identify which staff had the authority to apply or release a physical restraint device for residents.

When the home's written policy to minimize restraining of residents did not identify the duties and responsibilities of different staff, including who had responsibility and authority to apply and release restraints from a resident, residents were at increased risk of harm.

Sources: Interviews with the home's DOC and other staff; the home's Restraints/Personal Assistance Services Devices (PASD) Policy (ID# 03 – 01 – 02 / 08 – 01 – 06, last revised January 4, 2024)

B) The licensee failed to ensure the home's policy contained duties and responsibilities of staff, including ensuring that all appropriate staff were aware at all times of when a resident was being restrained by use of a physical device, as outlined in Ontario Regulation 246/22 s. 118 (b)(ii).

Rationale and Summary
The home's Restraints policy did not include duties and responsibilities of staff for ensuring all relevant staff were aware at all times when a resident was being restrained by a physical device.

When the home's written policy to minimize restraining of residents did not provide direction for staff duties and responsibilities, including ensuring all appropriate staff were aware at all times of when a resident was being restrained by a physical device, residents were at increased risk of harm.

Sources: Interviews with the home's DOC and other staff; the home's Restraints/PASD Policy (ID# 03 – 01 – 02 / 08 – 01 – 06, last revised January 4, 2024)

C) The licensee failed to ensure the home's policy contained how consent to the use of physical restraint devices under section 35 of the Act, or personal assistance service devices under section 36 of the Act, were to be obtained and documented, as required in Ontario Regulation 246/22 s. 118 (e).

Rationale and Summary
The home's Restraints policy did not contain how consent to the use of physical restraint devices was to be obtained and documented.

When the home's written policy to minimize restraining of residents did not include how consent to the use of physical restraint devices was to be obtained and documented, there was an increased risk of residents' relevant decision makers being inappropriately informed regarding residents' restraining.

Sources: Interviews with the home's DOC and other staff; the home's Restraints/PASD Policy (ID# 03 – 01 – 02 / 08 – 01 – 06, last revised January 4, 2024)

D) The licensee failed to ensure the home's written policy included alternatives to the use of physical restraint devices, including how the alternatives were planned, developed and implemented, using an interdisciplinary approach, as outlined in Ontario Regulation 246/22 s. 118 (f).

Rationale and Summary
The home's Restraints policy did not include alternatives to the use of physical

restraint devices, including how the alternatives were planned, developed and implemented, using an interdisciplinary approach.

Residents were at increased risk of inappropriate physical restraint use when the home's policy did not include how restraint alternatives were to be planned, developed and implemented using an interdisciplinary approach.

Sources: Interviews with the home's DOC and other staff; the home's Restraints/PASD Policy (ID# 03 – 01 – 02 / 08 – 01 – 06, last revised January 4, 2024)

E) The licensee failed to ensure the home's written policy contained how the use of restraining in the home would be evaluated to ensure minimizing of resident restraining, and to ensure that any restraining that is necessary is done in accordance with the Fixing Long Term Care Act and Ontario Regulation 246/22, as required as part of Ontario Regulation 246/22 s. 118 (g).

In accordance with Ontario Regulation 246/22 s. 122, every licensee shall ensure:

> (a) that an analysis of the restraining of residents by use of a physical device under section 35 of the Act or pursuant to the common law duty referred to in section 39 of the Act is undertaken on a monthly basis;
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> (b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 33 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
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> (c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;

(d) that the changes or improvements under clause (b) are promptly implemented; and

(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared.

Rationale and Summary

The home's Restraints policy did not include how the use of restraining in the home would be evaluated to ensure minimizing of restraining, and to ensure that any restraining deemed necessary was done in accordance with the Act and Regulation.

i) The home's monthly process for evaluating the use of restraints in the home was identified to not comply with requirements of the Act and Regulation.

ii) The home's annual evaluation of their Restraints policy on January 4, 2024 was identified to not comply with requirements of the Act and Regulation. A written record was not maintained of that evaluation process.

When the home's policy to minimize restraining of residents did not contain the elements required in Ontario Regulation 246/22 s. 118, residents with physical restraint devices at the home were at increased risk of inappropriate care.

Sources: Interviews with the home's DOC, Quality Assurance Nurse, and other staff; Resident #002's clinical records, and the home's Restraints/PASD Policy (ID# 03 – 01 – 02 / 08 – 01 – 06, last revised January 4, 2024)

2) The licensee failed to ensure the home's written policy for minimizing restraining of residents was complied with. In addition, the licensee failed to ensure the use of physical restraints was done in accordance with the Act and Regulation. Specifically, concerns were identified with adherence to Regulation's requirements for when residents' restraints were applied.

A) The licensee failed to ensure physical restraint devices under section 35 of the Act were not altered, except for routine adjustments in accordance with any manufacturer's instructions, as required by Ontario Regulation 246/22 s.119 (1)(3).

Rationale and Summary
The home's Restraints policy indicated residents' physical restraints were to only be applied in accordance with manufacturer's specification.

A resident's physical restraints were identified to have had two modifications between implementation and the time of inspection. The modifications were not in accordance with the manufacturer's specifications.

When a resident's physical restraints were modified outside of manufacturer's specifications, the resident was at increased risk of harm.

Sources: Interviews with the home's DOC and other staff; A resident's clinical records, the home's Restraints/PASD policy (ID#03 – 01 – 02 / 08 – 01 – 06, last reviewed on January 4, 2024)

B) The licensee failed to ensure a resident's physical restraint device was applied in accordance with any instructions specified by the physician, as outlined in Ontario Regulation 246/22 s. 119 (2)(2).

Rationale and Summary
The home's Restraints policy directed registered staff to obtain a physician's order within 12 hours, including the type of restraint. The resident's plan of care was to be updated regarding the use, type, and purpose of the restraint.

When a physical restraint was sought for residents by registered staff, a registered nurse (RN) described the home's process to include registered staff contacting the home's physician, and obtaining an order for the use of a physical restraint. They reported registered staff were responsible for gathering all instructions related to the order, and transcribing the order into the home's electronic order record platform Scriberly.

The process was identified to not have been followed for a resident at the home. The home's physician reported a different intention for the restraint's use than what was implemented at the home.

When staff did not comply with the home's policy in gathering the physician's order within 12 hours, including the use of the restraint, a resident was at increased risk of inappropriate restraint use.

Sources: Interview with an RN and other staff; A resident's clinical records, the home's Restraints/PASD policy (ID#03 – 01 – 02 / 08 – 01 – 06, last reviewed on January 4, 2024)

C) The licensee failed to ensure that registered staff, or staff authorized by a member of the registered nursing staff for that purpose, conducted hourly checks of a resident when their physical restraint device(s) were applied, as required by Ontario Regulation 246/22 s. 119 (2)(3).

Rationale and Summary
The DOC reported the home's hourly monitoring of all residents in physical restraints was conducted by personal support worker staff at the home, and not registered staff.

The home's Restraints policy indicated direct care givers were to document on (the home's electronic medical record) hourly. It did not indicate which staff should perform the hourly monitoring of residents when their physical restraints were engaged.

When the home's policy did not identify a process to ensure hourly monitoring was completed, staff were not aware of who was responsible for completing the task, and residents with physical restraints were at increased risk of inconsistent care.

Sources: Interviews with the home's DOC and other staff; A resident's clinical records, the home's policy for Restraints/PASD (ID#03 – 01 – 02 / 08 – 01 – 06, last reviewed on January 4, 2024)

D) The licensee failed to ensure a resident was released from their restraints, and repositioned every two hours when their restraints were applied, as required by Ontario Regulation 246/22 s.119 (2)(4). Additionally, they failed to ensure documentation was completed for each repositioning of a resident when their restraints were engaged, as well as who applied the restraints, and when they were applied, released, and removed, as outlined in Ontario Regulation s. 119 (7)(5), s. 119 (7)(6) and s. 119 (7)(7).

Rationale and Summary
The home's Restraints policy included procedures for unidentified staff to remove residents' restraints every two hours when engaged, including repositioning and

correct reapplication of restraints. Furthermore, the policy directed unidentified staff to document the release of restraints.

During the inspection, a resident was identified to not have been repositioned and released from their physical restraints every two hours when their restraints were engaged. It was further identified that the documentation of their every restraint engagement, release, reapplication, and removal was not consistently completed.

When a resident was not released from their restraints and repositioned every two hours, and the associated documentation was not completed, they were at increased risk of inconsistent care and harm.

Sources: Inspector observations during inspection, Interviews with the home's DOC, and other staff; A resident's clinical records, the home's policy for Restraints/PASD (ID#03 – 01 – 02 / 08 – 01 – 06, last reviewed on January 4, 2024)

E) The licensee failed to ensure a resident's condition was reassessed, and the effectiveness of their restraining, was completed at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, as required by Ontario Regulation 246/22 s. 119 (2)(6). Furthermore, documentation of the reassessments, including the resident's response, was not completed, as outlined in Ontario Regulation 246/22 s. 119 (7)(6).

Rationale and Summary
The home's Restraints policy directed registered staff to reassess residents' conditions, and evaluate the effectiveness of their restraining devices, at least once every 8 hours, as well as on an as needed basis. They were also to physically double check, and document on the home's electronic medical record, that a restraint had been applied correctly, and whether the resident was safe and comfortable.

A resident was identified to have not had their condition reassessed, and the efficacy of their restraining evaluated, every eight hours when their physical restraints were engaged. The home's documentation of the reassessments were not completed in a manner that supported evaluating the efficacy of restraining.

The resident was at increased risk of harm when registered staff did not conduct reassessments of the resident's condition, as well as the efficacy of restraining, at least every eight hours. Furthermore, the lack of required documentation for the reassessments put the resident at increased risk of unidentified trends and preventable harm.

Sources: Interviews with the home's DOC, and other staff; A resident's clinical records, the home's policy for Restraints/PASD (ID#03 – 01 – 02 / 08 – 01 – 06, last reviewed on January 4, 2024)

This order must be complied with by November 30, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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