1. The licensee did not ensure proper techniques were used to assist residents with eating at the lunch meal June 13, 2011. [O.Reg. 79/10, s.73(1)10.]

a) Staff assisting an identified resident with eating were scraping the resident's mouth with the spoon and mixing the pureed salad and pureed lasagna on the spoon.

b) Staff assisting an identified resident with eating were placing large quantities of food on the spoon and were mixing bread and lasagna on the spoon.

c) Staff assisting an identified resident with eating were scraping the resident's mouth with the spoon and did not use a napkin for removing food debris from the resident's mouth and face.

2. Tables at an appropriate height to meet the needs of all residents were not in place in the main dining area of the home. [O.Reg. 79/10, s.73(1)11.]
Only one table in the dining room was adjustable. There were numerous residents in the dining room that had large wheelchairs and could not be seated appropriately at the table in the large dining room. Staff interviewed stated that adjustable tables were going to be ordered, however, were not currently in place to meet the needs of residents.

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following subsections:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(a) cleaning of the home, including,**
**(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and**
**(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;**
**(b) cleaning and disinfection of resident care equipment, such as whirlpools, tubs, shower chairs, and lift chairs and supplies and devices, including personal assistance services devices, assistive aids, and positioning aids and contact surfaces, using hospital grade disinfectant and in accordance with manufacturer's specifications;**
**(c) removal and safe disposal of dry and wet garbage; and**
**(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

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**Findings/Faits sayants :**

1. Procedures are not consistently implemented for the cleaning of the home including the common areas, specifically floors. [O.Reg. 79/10, s.87(2)(a)(ii)]
On June 13, 2011, it was noted that the floor in the spa area was discoloured with large black areas near the door to the room. During an interview with the Director, Environmental Services it was confirmed that the floor in the spa area was discoloured from a build up of products and that previous attempts to remove were unsuccessful. On June 27, 2011, the floor in the spa area was again observed and at this time it was clean with no evidence of black discolouration or build up. Staff present on June 27, 2011, indicated that the floor has just been cleaned by an outside company to remove the discolouration.

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**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following subsections:**

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;**
**(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;**
**(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;**
**(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;**
**(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;**
**(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;**
**(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;**
**(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;**
**(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;**
**(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and**
**(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).**

**Findings/Faits sayants :**

1. Procedures are not implemented to ensure that hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service.[O.Reg. 79/10, s.90(2)(f)] During a tour of the Maintenance room on June 23, 2011, with the maintenance staff, the hot water heater and storage tank were observed, both pieces of equipment have attached stickers which identify the last date of service or inspection. According to the posted sticker, which was confirmed by the maintenance staff, the hot water heater is a rented unit which was last inspected on June 14, 2001 and the water storage tank was last inspected September 2010 with the next scheduled inspection to be conducted in 2013.

***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 procedures are developed and implemented to ensure hot water boilers and hot water holding tanks are serviced at least annually and that documentation is kept of the service, to be implemented voluntarily.***

**WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following subsections:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**1. Customary routines.**
**2. Cognition ability.**
**3. Communication abilities, including hearing and language.**
**4. Vision.**
**5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.**
**6. Psychological well-being.**
**7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.**
**8. Continence, including bladder and bowel elimination.**
**9. Disease diagnosis.**
**10. Health conditions, including allergies, pain, risk of falls and other special needs.**
**11. Seasonal risk relating to hot weather.**
**12. Dental and oral status, including oral hygiene.**
**13. Nutritional status, including height, weight and any risks relating to nutrition care.**
**14. Hydration status and any risks relating to hydration.**
**15. Skin condition, including altered skin integrity and foot conditions.**
**16. Activity patterns and pursuits.**
**17. Drugs and treatments.**
**18. Special treatments and interventions.**
**19. Safety risks.**
**20. Nausea and vomiting.**
**21. Sleep patterns and preferences.**
**22. Cultural, spiritual and religious preferences and age-related needs and preferences.**
**23. Potential for discharge. O. Reg. 79/10, s. 26 (3).**

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**Findings/Faits sayants :**

1. The plan of care is not always based on an assessment of safety risks.[O.Reg. 79/10, s.26(3)19]

a) An identified resident does not have an interdisciplinary assessment related to safety risk and the use of two bed rails. A PSW interviewed indicated that the resident uses two bed rails when in bed. There is a physician order for the use of bed rails. A review of the medical record was unable to produce an interdisciplinary assessment related to the use of bed rails for the resident.

b)The plan of care for an identified resident is not based on an interdisciplinary assessment with respect to resident safety risks. The plan of care related to Risk of Falls was established in July 2010 and indicated that bed rails should be up when the resident is in bed. There is no record within the plan of care of an assessment having been completed related to the use of bed rails for the resident. The Executive Director confirmed during interview that the use of bed rails for this resident has not been considered a restraint and the policy related to restraints has not been followed. No interdisciplinary assessment has been completed.

***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 plan of care includes safety risks, to be implemented voluntarily.***

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**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following subsections:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).**

**s. 30. (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. O. Reg. 79/10, s. 30 (2).**

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**Findings/Faits sayants :**

1. Not all actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.[O.Reg. 79/10, s.30(2)]

a) The licensee did not ensure that actions taken with respect to an identified resident, under the Recreation program, including interventions and the resident's responses to interventions were documented. Documentation does not include preferred activities for 1:1 programs offered to the resident, and does not include the resident's responses to the 1:1 programming for the months of May and June 2011. Staff interviewed were able to provide examples of preferred activities and strategies to use when providing 1:1 visits, however, these were not documented or included in the resident's plan of care. (107)

b) Point of care documentation was reviewed on June 27, 2011 for the past 30 days for three residents regarding interventions under the continence care and bowel management program.
i) There were only three documented incidents of toilet use each day for three identified residents documented between May 29, 2011 and June 24, 2011. Staff confirm that the residents were toileted more often, especially during the day shift.

c) There is a discrepancy among the staff who enter the information into the computer regarding how often the documentation should be done in a shift (e.g., some staff report once per shift, others report they would only document a second time if there was a change, and some report they should be documenting every time the resident is toileted, whether independently or with assistance). The Promoting Continence policy (#008010.00) indicates "document all voiding and bowel activity on the resident's Point of Care screen".

2. Not all programs include a written description that includes goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.
[O.Reg. 79/10, s.30(1)1.]

a) The home does not have an organized program for Restorative Care that includes goals and objectives, relevant policies and procedures, methods to monitor outcomes and protocols for referral of residents. Discussion with the Executive Director confirms that there is no current program for Restorative Care. Plans are in place to replace the current physiotherapy provider as of August 1, 2011 and it is anticipated that an organized program of Restorative Care will be in place following this change.

b) The home does not have goals and objectives for the Accommodation Program including laundry, housekeeping and maintenance. A review of the policy and procedure manual and interview with the Executive Director confirm that goals and objectives are not available for this program.

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*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 all organized programs required under sections 8 to 16 of the Act have goals, objectives, relevant policies, procedures and protocols and ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and residents' responses to interventions are documented, to be implemented voluntarily.***

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement**
**Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:**
**1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.**
**2. The system must be ongoing and interdisciplinary.**
**3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.**
**4. A record must be maintained by the licensee setting out,**
**i. the matters referred to in paragraph 3,**
**ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and**
**iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.**

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**Findings/Faits sayants :**

1. Results of audits, quality indicators, and quality improvement initiatives have not been communicated to the Resident's Council or Family Council [O.Reg. 79/10, s.228.3].
Two of three residents interviewed stated that the home does not share information related to changes made or quality improvement initiatives. A review of the Resident Council minutes found no evidence of discussion related to quality improvements made to the accommodations, care, services, programs and goods provided to residents. The home has both a new management company (PeopleCare) and a new Executive Director and has adopted the policies of this management company. There is no reference to communication of this information within the Residents' Council minutes reviewed between January and May 2011.

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**WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs**
**Every licensee of a long-term care home shall ensure that,**
**(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and**
**(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.**

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**Findings/Faits sayants :**

1. Not all medical directives for the administration of drugs to residents is individualized to the resident's condition and needs. [O.Reg. 79/10, s.117(b)]
An identified resident has a documented allergy to a specific medication, which had been identified in the resident's clinical record and noted by the pharmacist during a written recommendation in March, 2011. The physician signed the Medical Directives for the resident and ordered the medication that the resident was identified as being allergic to. During an interview with the ADOC on June 20, 2011, it was confirmed that the physician signs the Medical Directives but does not individualize these orders to the needs of residents, specifically allergies.

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*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 medical directives are individualized to each resident's condition and needs, to be implemented voluntarily.***

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**WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 10 centimetres. O. Reg. 79/10, s. 16.**

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**Findings/Faits sayants :**

1. Outdoor windows, which are accessible to residents do not have their opening restricted.[O.Reg. 79/10, s.16]
On June 15, 2011 a number of windows in resident rooms were randomly checked for ability to open, inward tilt style windows were observed to open fully to approximately 22 cm. During an interview with the Director, Environmental Service on June 20, 2011, it was confirmed that the windows in the home, which are accessible to residents, have not been restricted for opening size. The Executive Director reported that effective June 20, 2011, environmental services staff will adapt all windows, which residents have access to, in order to limit the opening size.

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**WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.TABLEHomes to which the 2009 design manual appliesLocation - LuxEnclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 322.92 lux continuous consistent lighting throughoutIn all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 luxAll other homesLocation - LuxStairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 215.28 lux continuous consistent lighting throughoutIn all other areas of the home - Minimum levels of 215.84 luxEach drug cabinet - Minimum levels of 1,076.39 luxAt the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 luxO. Reg. 79/10, r. 18, Table.**

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**Findings/Faits sayants :**

1. Not all lighting requirements are maintained, specifically at the bed of each resident while the bed is at the reading position to a minimum level of 376.73 lux. [O.Reg. 79/10, s.18]
During a tour of the home it was observed that lightening levels appeared low at the bed of residents in five identified rooms. During an interview with the Executive Director of the home it was reported that an electrician conducted a random room audit in the home on June 21, 2011, with a light meter and reported lux levels at resident beds in the reading position to be only 190 lux which is below the minimum level of 376.73 lux.

*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 lighting requirements set out in the regulations are adhered to and maintained, to be implemented voluntarily.***

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**WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference**

**Specifically failed to comply with the following subsections:**

**s. 27. (1) Every licensee of a long-term care home shall ensure that,**
**(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any;**
**(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and**
**(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).**

**Findings/Faits sayants :**

1. A record was not kept of the participants and the results of the annual conference for an identified resident in March, 2011. [O.Reg. 79/10, s.27(1)(c)]
The annual care conference progress note was reviewed for the identified resident. The documentation did not include the participants of the meeting or the results of the conference, including a specific care request from the resident's substitute decision maker. This request is not included in the care plan summaries completed in March 2011 and June 2011. Three PSW's interviewed were unaware of this request by the resident's substitute decision maker. There is no documentation that would indicate a reason for not following this request.

**WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care**

**Specifically failed to comply with the following subsections:**

**s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,**
**(a) mouth care in the morning and evening, including the cleaning of dentures;**
**(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and**
**(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).**

**Findings/Faits sayants :**

1. Not all residents receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening and/or cleaning of dentures. [O.Reg. 79/10, s.34(1)(a)]
An identified resident was noted to have dentures with debris around the gum line on June 15, 16, and 21, 2011. During interviews two residents reported that they do not receive oral care in the morning and evening and cleaning of dentures. PSW staff interviews on June 21, 2011 have indicated that oral care for those residents with dentures involves brushing and soaking the dentures at night followed by rinsing the dentures in the morning before assisting the resident with inserting the dentures. This description of care is not consistent with cleaning twice a day.

***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 each resident of the home receives mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.***

**WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following subsections:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;**
**(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;**
**(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;**
**(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;**
**(e) continence care products are not used as an alternative to providing assistance to a person to toilet;**
**(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;**
**(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and**
**(h) residents are provided with a range of continence care products that,**
**(i) are based on their individual assessed needs,**
**(ii) properly fit the residents,**
**(iii) promote resident comfort, ease of use, dignity and good skin integrity,**
**(iv) promote continued independence wherever possible, and**
**(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).**

**Findings/Faits sayants :**

1. Not all residents who are incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [O.Reg. 79/10, s.51(2)(a)]
The assessments documented in Point Click Care were reviewed for three residents:

a) For one identified resident, the Quarterly Continence Review in May, 2011 indicated there had been a change in the resident's continence, specifically increased bowel incontinence, however there were no assessments regarding causal factors, patterns or potential to restore function. The Executive Director and ADOC confirmed that this information was missing from the plan of care and would be expected to be included.

b) For an identified resident, the RAP documentation for October 2010, January 2011 and April 2011 and the Quarterly Continence Review in April 2011 were reviewed. These assessments do not include information regarding patterns of incontinence. The plans of care for the above months all include the interventions to "evaluate resident's bladder control pattern" and "identify trigger meal" for bowel incontinence, however no assessment or evaluation of these patterns were included in the assessments. The Executive Director and the ADOC confirm that these interventions should have been assessed after the first quarter (i.e., October 2010) in order to update the care plans in January and April 2011.

c) For an identified resident, the RAP documentation for October 2010, January 2011 and April 2011 and the Quarterly Continence Review in April 2011 were reviewed. These assessments do not include information regarding his potential to restore function with specific interventions. The RAP assessments have been identical in each of the three quarters listed. The Executive Director and ADOC confirm that a more complete assessment would be expected regarding the resident's continence due to the decline in function noted in October 2010.

***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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, types of incontinence and potential to restore function with specific interventions, to be implemented voluntarily.***

**WN #26: 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 subsections:**

**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**
**(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).**

**Findings/Faits sayants :**

1. The licensee did not ensure that there is a written policy to minimize the restraining of residents and to ensure any restraining that is necessary is done in accordance with this Act and the regulations. [LTCHA, 2007, S.O. 2007, c.8, s.29(1)] The home's policy Restraints Protocol #004030.00 dated effective February 28, 2011 does not give clear direction to staff that bed rails and tilt chairs may be a restraint in some circumstances. The home's policy on Restraint use indicates that "bed rails are not a restraint", however, the home is currently using bed rails as a restraint for identified residents.

a) Progress notes reviewed indicate that an identified resident uses two full bed rails during the night as the resident tries to self transfer.

b) Observation and documentation indicate that an identified resident uses two bed rails to prevent the resident from falling from the bed and a tilt chair for comfort and safety.

Discussion with the Executive Director confirms that the policy is unclear and that staff could misunderstand the intent of the policy believing that bed rails are not a restraint. Discussion with Director of Policy and Legislation for PeopleCare confirms that bed rails may at times be considered a restraint and that the policy may lead front line staff to believe bed rails are not a restraint.

***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 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, to be implemented voluntarily.***

**WN #27: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining**

**Specifically failed to comply with the following subsections:**

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

**Findings/Faits sayants :**

1. The licensee has not ensured that all residents that use restraints do so in accordance with section 31 of the Act. [LTCHA, 2007, S.O.2007, c.8,s.30(1)3.]

a) As per section 31(1) residents are only to be restrained by a physical device if the restraining of the resident is included in the plan of care.
i)The use of restraint by a physical device is not included in the plan of care for an identified resident. Two bed rails are used for the resident, to prevent falls when in bed, as confirmed during interview with a PSW and supported by Point of Care documentation indicating that bed rails are applied when in bed.
ii) PSW staff confirm that an identified resident uses two bed rails when in bed. An interview with the ADOC indicates that the resident is unable to move out of the bed independently. There is concern that they may fall out of bed with out bed rails in place. Point of care documentation from June, 2011 indicates that two bed rails are up while in bed.

b) As per section 31(2)2 regarding the consideration of alternatives to restraining. The plan of care for an identified resident does not include alternatives to restraining that were considered and tried but have not been effective in addressing the risk of falls. Two full bed rails are observed in use for the resident, preventing the resident from exiting the bed. The plan of care indicates two bed rails are to be up when the resident is in bed due to a risk of falls.

c) As per section 31(2)4 regarding restraints being ordered by a physician or nurse in the extended class. An identified resident's plan of care does not include an order or approval for a restraint by a physician or nurse in the extended class.

d) As per section 31(2)5 regarding consent of the resident or the resident's substitute decision maker for the use of restraints.
i) An identified resident does not have a consent form signed for the use of two bed rails to prevent independent mobility. The resident has an order for the use of bed rails. A PSW interviewed indicated that two bed rails have been used for the resident each evening until June, 2011. A review of the medical record was unsuccessful in locating a consent for the use of two bed rails.
ii)The plan of care for an identified resident does not include a signed consent form from the resident or substitute decision maker for use of bed rails as a restraint. Two full bed rails are observed in use for an identified resident, preventing the resident from exiting the bed.

**Issued on this 9th day of August, 2011**

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