



**Inspection Report  
under the *Long-Term  
Care Homes Act, 2007***

**Rapport d'inspection  
prévue le *Loi de 2007  
les foyers de soins de  
longue durée***

**Ministry of Health and Long-Term Care**

Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

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**Ministère de la Santé et des Soins de  
longue durée**

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Licensee Copy/Copie du Titulaire       Public Copy/Copie Public

<b>Date of inspection/Date de l'inspection</b> October 6 and 7, 2010	<b>Inspection No/ d'inspection</b> 2010_147_2745_21Oct143440	<b>Type of Inspection/Genre d'inspection</b> Critical Incident – H-01076
<b>Licensee/Titulaire</b> Holland Christian Homes Inc. 7900 McLaughlin Road South Brampton, ON L6Y 5A7		
<b>Long-Term Care Home/Foyer de soins de longue durée</b> Faith Manor 7900 McLaughlin Road South Brampton, ON L6Y 5A7		
<b>Name of Inspector</b> Laleh Newell - #147		
<b>Inspection Summary/Sommaire d'inspection</b>		

The purpose of this inspection was to conduct a Critical Incident inspection related to improper care that resulted in harm to resident.

During the course of the inspection, the inspector spoke with:

Director of Care, Assistance Director of Care and registered staff on the unit.

During the course of the inspection, the inspector:

Reviewed resident's clinical chart, reviewed home's policy and procedure related to restraints, reviewed internal incident and investigation reports, observed care and observed resident and staff in routine duties.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

Findings of Non-Compliance were found during this inspection. The following action was taken:

[2] WN

[2] VPC

### NON-COMPLIANCE / (Non-respectés)

#### Definitions/Définitions

WN – Written Notifications/Avis écrit

VPC – Voluntary Plan of Correction/Plan de redressement volontaire

DR – Director Referral/Régisseur envoyé

CO – Compliance Order/Ordres de conformité

WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

**WN #1:** The Licensee has failed to comply with – LTCHA, 2007, S.O. 2007, c.8, 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.

#### Findings:

1. An identified resident was assessed in November 2007 to require a seatbelt with tabletop for safety while in wheelchair; however in August 2010 the resident was in the wheelchair and being closely monitored by the staff close to the nursing station for agitation and safety. The resident was found by the staff to have slid under the seatbelt restraint with the seatbelt around the abdominal area. Documentation and the home's Restraint Form does not support that resident had the tabletop



attached to the wheelchair as per physician's orders at the time of the incident.  
2. According to the care set out in the plan of care, the home failed to ensure the resident had the tabletop attached to her wheelchair for safety while in her wheelchair.

Inspector ID #: 147

**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 the residents care set out in the plan of care are provided as specified in the plan, to be implemented voluntarily.

**WN #2:** The Licensee has failed to comply with – O.Reg. 79/10, s. 110(7)(6)  
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:  
6. All assessment, reassessment and monitoring, including the resident's response.

**Findings:**

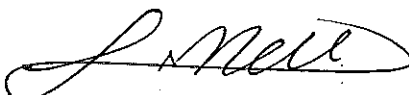
1. An identified resident was being closely monitored by the registered staff during the night shift on August 22, 2010 due to agitation and safety. At approximately 0430am the resident had slid down under the seatbelt and was found with the seatbelt around the resident's abdominal area. However, according to the home's Restraint Form sheet the resident was not being monitored or reassessed related to the resident's response while in the wheelchair during the time of the incident (2400 to 0700).
2. An identified was assessed in November 2007 to require a seatbelt with tabletop for safety while in her wheelchair, however, there are no documentation to support that the staff had been continuing to monitor the resident's response while in her wheelchair for the month of September and October 2010.

Inspector ID #: 147

**Additional Required Actions:**  
VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all resident's responses related to restraints are being documented, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee  
Signature du Titulaire du représentant désigné

Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.

 Feb 10/11

Title: Date:

Date of Report: (if different from date(s) of inspection).