Ontario

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

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
May 12 and 13, 2011	2011_106_9608_12May151729	Complaint Inspection

Licensee/Titulaire
Kenora District Home for the Aged Board of Management
35 Van Horne Avenue, Box 725, Dryden, ON P8N 2Z4

Long-Term Care Home/Foyer de soins de longue durée
Princess Court
Princess Street, Box 725, Dryden, ON P8N 2Z4

Name of Inspector(s)/Nom de l'inspecteur(s)
Margot Burns-Prouty (106)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with: Director of Care, RAI Coordinator, Registered Practical Nurses, Personal Support Workers, and Residents

During the course of the inspection, the inspector: Conducted a walk-through of all resident home areas and various common areas, observed care provided to residents in the home, reviewed electronic plans of care, reviewed written plans of care, reviewed progress notes, and interviewed staff members.

The following Inspection Protocols were used during this inspection: Dining Observation, Snack Observation, Medication, Minimizing of Restraining, and Nutrition and Hydration.

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

5 WN

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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Findings:

1. On May 12, 2011 at approximately 1815h, a student RPN was observed to administer eye drops to a resident in the dining room, during evening snack in front of other residents. The licensee failed to ensure this resident's right to be afforded privacy in treatment and in caring for their personal needs. [s. 3. (1) 8] (106)
2. On May 12, 2011 at approximately 1815h, a student RPN was observed to administer eye drops and a puffer inhalation treatment to a resident in the hallway beside the dining room and in front of other residents. The licensee failed to ensure this resident's right to be afforded privacy in treatment and in caring for their personal needs. [s. 3. (1) 8] (106)

Inspector ID #: 106

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 31 (1): A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care.

Findings:

1. On May 12, 2011, at 1955h inspector 106 observed a restraint used on a resident. The plan of care for this resident was reviewed, there was no documentation found related to the use of the restraint. A RPN also verified the use of the restraint for this resident, to inspector 106. The licensee failed to ensure that a resident who is restrained by a physical device as described in paragraph 3 of subsection 30 (1), is included in the resident's plan of care. [s. 31 (1)] (106)

Inspector ID #: 106

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 31(2): The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

Findings:

On May 12, 2011, at 1955h inspector 106 observed a restraint used on a resident. No documentation was found from a physician, registered nurse in the extended class or other person provided for in the regulations related to who has ordered or approved the restraining. The licensee failed to ensure that a resident who was restrained by a physical device on May 12, 2011, had an order or approval for the restraining by a physician, registered nurse in the extended class or other person provided for in the regulations. [s. 31 (2) 4.] (106)

Inspector ID #:	106

WN #4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 31(2): The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Findings:

1. On May 12, 2011, at 1955h inspector 106 observed a restraint used on a resident. No consent, by the resident or Substitute Decision Maker for the use of this restraint was found in the resident's health care record. The licensee failed to ensure that the restraining of a resident by a physical device on May 12, 2011, had been consented to by the resident or, if the resident incapable, a substitute decision-maker of the resident with authority to give that consent. [s. 31 (2) 5.] (106)

Inspector ID #:	106

WN #**5:** The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6 (5): The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Findings:

1. The SDM for a resident participated in care conferences for a resident and their wishes regarding the use of the resident's restraint are documented. The manner in which the restraint is used for this resident is not reflective of the SDM's wishes. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Inspector ID #:	106

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.**
Title: **Date:**	**Date of Report:** October 18, 2011