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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Dec 12, 2014	2014_332575_0015	S-002057/2065/2066/2067-11	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE
70 Spine Road ELLIOT LAKE ON P5A 1X2

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

ST. JOSEPH'S MANOR
70 SPINE ROAD ELLIOT LAKE ON P5A 1X2

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

LINDSAY DYRDA (575)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 9-12, 2014

10 Critical Incident(s) (CI) were inspected during this inspection.

A follow-up inspection was also completed concurrently during this inspection. Additional non-compliance from this inspection can be found in inspection #2014_336580_0018.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Registered Staff, Personal Support Workers (PSW), and Residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Inspector #575 reviewed a CI and the health care record regarding resident #009. The resident sustained a fall which resulted in the resident being hospitalized for sustaining a fracture. The resident was re-admitted to the home a few weeks later. Inspector #575 noted upon return from hospital, progress notes indicated new interventions regarding the required care for the resident. The inspector reviewed the most recent care plan and noted that the new interventions were not mentioned. The Administrator/DOC confirmed to the inspector that the PSWs are to review the care plan for current directions and they would not routinely review the progress notes, thus would not have had the up to date information.
Upon further review, the inspector noted that in the care plan under the problem sections titled 'Walk in Room' and 'Walk in Corridor', the interventions suggest that staff were to provide the resident standby assistance when walking, ensure the resident was wearing firm, sturdy, non-slip shoes, and walk with the resident from his/her room to the nursing station; however, under the problem section 'Wandering', the interventions stated that the resident can no longer ambulate and is to remain safely in his/her wheelchair.
The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #009. [s. 6. (1) (c)]

2. Inspector #575 reviewed a CI and the health care record regarding resident #008. The resident sustained a fall which resulted in a fracture. The resident's most recent fall

assessment identified the resident as being at 'extreme risk' for falls. On Sept 10, 2014 the inspector interviewed the Administrator/DOC who told the inspector that fall assessments are completed annually, and also after any fall. The Administrator/DOC stated that staff refer to the 'leaflets' located on the resident's bed to determine if a resident is at low or high risk for falls; a 'green leaf' indicates low risk and a 'amber leaf' indicates high risk. On Sept 10, 2014 the inspector observed a 'green leaf' on the resident's headboard.
The inspector interviewed 2 staff members (#100 and #200) who both stated that residents at risk for falls are identified via the 'fall leaf' located on the resident's headboards; green=low risk, amber=high risk. Additionally, staff member #200 stated that resident #008 would be a yellow leaf or high risk. Inspector interviewed staff member #201 who told the inspector that staff would look at the care plan for information regarding the resident's care. The most recent care plan for resident #008 was reviewed and the inspector noted that the resident's risk for falls was also not documented.
The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #008. [s. 6. (1) (c)]

3. Inspector #575 reviewed a CI and the health care record regarding resident #002. The resident sustained a fall in 2011. The inspector noted that the long-term actions planned to prevent recurrence included that the resident was not to be left alone in their room until their current wheelchair has been assessed. The Administrator/DOC confirmed to the inspector that resident #002 was not left alone in their room. The inspector reviewed the health care records for resident #002 and determined the referral for the wheelchair to be assessed was not submitted for approximately 2 months following the fall and had not been completed. The care plan for resident #002 did not identify that resident #002 was not to be left alone in their room until the assessment was completed. Therefore, the licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #002. [s. 6. (1) (c)]

4. Inspector #575 reviewed a CI and the health care record regarding resident #001. The CI indicated that resident #001 sustained a fall and used a lap belt when in their wheelchair. The inspector reviewed the resident's health care record and did not find any reference for the use of a lap belt. The Administrator/DOC told the inspector during an interview that the resident was cognitive, physically capable of removing the belt, and liked to wear it for safety.
The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident in regards to the use of a lap belt. [s. 6. (1) (c)]

5. Inspector #575 reviewed a CI and the health care record regarding resident #008. Resident #008 sustained a fall which resulted in a fracture. The inspector reviewed the most recent care plan for resident #008. The care plan identified that staff are to attach a bed alarm when the resident is resting in bed and place a mattress (fall mat) on the floor to prevent falls. On Sept 10, 2014 the inspector observed resident #008's room and did not see a fall mat on the floor or in the room and did not see a bed alarm. The inspector interviewed staff member #201 who told the inspector that the resident does not have a bed alarm. The staff member also confirmed to the inspector that resident #008 does not have a fall mat in their room and stated that if the fall mat was not in the resident's room, then the resident was not using one. The inspector interviewed staff member #100 who stated that resident #008 does not have a bed alarm or a fall mat. They stated that the resident used to use both 'in the beginning' (the staff member was unsure when), but the resident does not require the bed alarm and fall mat anymore. The staff member told the inspector that they realize the bed alarm and fall mat are still in the care plan, however they stated it is hard to keep up with updating the care plans.
The licensee has failed to ensure that resident #008 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

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 ensuring that written plans of care set out clear directions to staff and others who provide direct care to residents in regards to fall prevention, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Inspector #575 reviewed 9 critical incidents relating to resident falls that occurred in 2011 and 2012 for 9 different residents. The inspector reviewed the home's policy titled 'Fall Prevention/Management Program' last revised June 2012. The inspector noted that the policy indicated that registered nursing staff are to complete a 'Post Fall Screen for Resident/Environmental Factors' after a resident has fallen. The inspector was unable to locate this form in any of the 9 resident's health care records. The inspector interviewed the Administrator/DOC regarding the location of this form. The staff member stated that during 2011 and 2012 when these falls occurred she was working as a RN on the floor (she became Administrator/DOC in September 2013) and that form was never used. The Administrator/DOC stated that the form would not be found in any of the resident's charts and further stated that she is not sure why, but the form was not used or communicated to staff to use after a fall. Additionally, the Administrator/DOC stated that a new post falls checklist has been implemented, however the inspector noted that the checklist was not added to the policy and the Administrator/DOC indicated that it would be added to the policy within the month. Further, the inspector interviewed several staff members who indicated that residents who are at risk of falls are identified via the 'fall leaf' located on each resident's headboard. The inspector noted that the policy provided did not include the use of the 'fall leaf' however noted that the following was hand written into a policy found posted on the first floor home area: 'fall leaf at bedside- green = med risk, amber = high risk'. The inspector confirmed with Administrator/DOC that the leaflets were not included in the most recent policy that was provided to the inspector.
The licensee has failed to ensure that the home's 'Fall Prevention/Management Program' policy is in compliance with and is implemented in accordance with all applicable requirements under the Act, and is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 ensuring that the home's policy titled 'Fall Prevention/Management Program' is in compliance with and is implemented in accordance with all applicable requirements under the Act, and is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).

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:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

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:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

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. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Inspector #575 reviewed resident #008's health care record regarding the use of restraints. The inspector noted that the care plan indicated that PSWs are to sign the restraint sheet accordingly while the restraint device is in use. Resident #008 was ordered 2 different restraints. The inspector reviewed the restraint observation form completed by the PSWs and noted that the record does not include the circumstances precipitating the application of the device.
The licensee has failed to ensure that the documentation include the circumstances precipitating the application of the physical device. [s. 110. (7) 1.]

2. Inspector #575 reviewed resident #008's health care record regarding the use of restraints. The inspector noted that there was no documentation regarding what alternatives to restraints were considered and why those alternatives were inappropriate. The inspector reviewed the home's policy titled 'Minimizing Restraining of Residents: Use of Restraints' last revised May 2011 that indicated that staff are to document these findings on the 'Alternative Treatments to Restraints'. The Administrator/DOC confirmed to the inspector that this document was not completed.
The licensee has failed to ensure that the documentation include what alternatives were considered and why those alternatives were inappropriate. [s. 110. (7) 2.]

3. Inspector #575 reviewed resident #008's health care record regarding the use of restraints. The resident's care plan indicated that PSWs are to sign the restraint sheet accordingly while the device is in use. The inspector reviewed the restraint observation form used by the home and noted that the form does not indicate who applied the device. Further, the restraint observation form does not indicate what device was applied.
The licensee has failed to ensure that the documentation include the person who applied the device and the time of application and what device was applied. [s. 110. (7) 5.]

4. Inspector #575 reviewed resident #008's health care record regarding the use of restraints. The resident's care plan indicated that PSWs are to sign the restraint sheet accordingly while the device is in use. The inspector reviewed the restraint observation forms for resident #008 for a period of three months. The inspector noted that documentation was missing during 22 shifts during that period. The dates identified were compared to the MAR which indicated the resident was present in the home.
The licensee has failed to ensure that the documentation include every release of the device and repositioning. [s. 110. (7) 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 ensuring that the documentation regarding the use of a physical device to restrain a resident includes the circumstances precipitating the application of the physical device, alternatives that were considered and why those alternatives were inappropriate, includes the person who applied the device and the time of application, what device was applied, and every release of the device and repositioning, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 30 (1).
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. O. Reg. 79/10, s. 30 (1).
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. O. Reg. 79/10, s. 30 (1).
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).

Findings/Faits saillants :

1. The 'Fall Prevention and Management Program' last reviewed June 2012 was provided to inspector #575 by the Administrator/DOC. During an interview, the Administrator/DOC confirmed to the inspector that the program is not evaluated and reviewed annually, however it is something the home is going to be implementing. There are no written records relating to such evaluations. The licensee has failed to ensure that the following is complied with in respect of each of the organized programs required under section 48 of this Regulation in that 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. [s. 30. (1) 3.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Inspector #575 reviewed a CI submitted by the home in 2013. The CI was submitted 6 days after the incident and it identified that some of the doors on the electronic system with magnetic bars that hold the doors closed did not lock. The doors that did not lock

were the 2nd floor lobby doorway to stairwell, 1st floor lobby main exit door, 1st floor lobby hospital link door and basement hospital link door. The CI identifies that it was decided to bring in other staff for security/patient safety. The next morning maintenance was able to isolate the issue to the ground floor link to the hospital (no direct access for residents) and the rest of the hospital was in working order again. The ground floor link to the hospital was fixed on 4 days later. During an interview with the Administrator/DOC on September 9, 2014, it was confirmed that the doors remained unlocked for approximately 12.5 hours and during this time 2 extra staff were brought in to watch the doors. The Administrator/DOC did not know why there was a delay in reporting the incident.
The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of the incident of an environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home. [s. 107. (3)]

2. Inspector #575 reviewed a CI submitted in 2011. The report indicated that resident #003 sustained a fall that resulted in admission to hospital with a fracture. The inspector noted that the original CI was submitted 14 days after the incident occurred and not within the required 3 business days.
The licensee has failed to ensure that where an incident has occurred that caused an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, that the licensee contacts the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident. [s. 107. (3.1)]

3. Inspector #575 reviewed a CI submitted in 2011. The report indicated that resident #003 sustained a fall that resulted in admission to hospital with a fracture. After review of the health care record, the inspector determined that the CI did not indicate the correct date of the incident.
A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the

Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
The licensee has failed to ensure the correct date of the incident was included on the report to the Director.

The licensee has failed to make a report in writing to the Director of any of the incidents described in r. 107 (1), (3) or (3.1), within 10 days of becoming aware of the incident [s. 107. (4) 1.]

4. Inspector #575 reviewed a CI submitted 2012. The inspector noted that the identifying information including the names of any residents involved, the names of any staff who were present, and the names of the staff members who responded to the incident were not included in the report. The report was amended 22 days later to include the previous information. Subject to O.Reg.79/10, s. 107. (4), a licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including:
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
The licensee has failed to ensure that the written report included a description of the individuals involved in the incident, including the names of any residents involved, the names of any staff who were present, and the names of the staff members who responded to the incident. [s. 107. (4) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(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. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. Inspector #575 reviewed the home's policy titled 'Minimizing Restraining of Residents: Use of Restraints' last revised May 2011. The inspector noted that the policy does not indicate what types of physical devices are permitted to be used and merely states, 'Only legally approved, commercially made physical restraints may be used in accordance with manufacturer's specifications and directions'. The inspector noted that resident #008's plan of care identified that staff are to alternate tilt of the resident's wheelchair for comfort. Staff member #100 told the inspector that they do occasionally tilt the resident's wheelchair for comfort. The staff member stated that they do not consider tilting resident #008's wheelchair a restraint.
The licensee has failed to ensure that the policy address types of physical devices permitted to be used. [s. 109. (d)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 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;
(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.
O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. Inspector #575 reviewed the home's policy titled 'Restraints: Physical & Chemical' originated in 2002, last reviewed April 2011 and last revised May 2011. During an interview, the Administrator/DOC told the inspector that the restraint policy is not evaluated annually, however it is something they are going to be implementing. There are no written records relating to such evaluations or changes and improvements.
The licensee has failed to ensure that once in every calendar year an evaluation is conducted to determine the effectiveness of the policy, and identifies what changes and improvements are required to minimize restraining and ensure that restraining is done in accordance with the Act and Regulations. [s. 113. (b)]

Issued on this 30th day of December, 2014

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

Original report signed by the inspector.