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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2019	2019_727695_0013	030381-18, 030386-18, 030388-18, 030390-18, 030391-18, 006132-19	Follow up

Licensee/Titulaire de permis

Stayner Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Stayner Care Centre
244 Main Street East, 7308 Highway #26, P.O. Box 350 STAYNER ON L0M 1S0

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

FARAH_ KHAN (695), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 14, 15, 16, 17, 21, 22, 23, and 24, 2019.

During the course of the inspection, the following Critical Incident intakes were inspected:
Log #006132-19, related to the use of a prohibited restraint

During the course of the inspection the following follow-ups to Compliance Orders was conducted:
Log #030381-18, related to PASD use in the home, Compliance order #001 issued under Inspection #2018_737640_0021
Log #030386-18, related to the falls prevention and management policy, Compliance order #002 issued under Inspection #2018_737640_0021.
Log #030388-18, related to the falls prevention and management assessment tool, Compliance order #003 issued under Inspection #2018_737640_0021.
Log #030390-18, related to skin and wound care, Compliance order #004 issued under Inspection #2018_737640_0021.
Log #030391-18, related to pain management of residents', Compliance order #005 issued under Inspection #2018_737640_0021.

During the course of the inspection the inspectors observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records, policies and procedures, annual evaluation, training records, and meeting minutes, and observed infection prevention and control practices.

During the course of the inspection, the inspector(s) spoke with residents, personal support workers (PSW), laundry staff, registered practical nurses (RPN), registered nurses (RN), RAI Coordinator/Staff Educator, the Director of Care (DOC), and the Executive Director.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Pain
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 33. (3)	CO #001	2018_737640_0021	695
O.Reg 79/10 s. 48. (2)	CO #003	2018_737640_0021	695
O.Reg 79/10 s. 50. (2)	CO #004	2018_737640_0021	695
O.Reg 79/10 s. 52. (2)	CO #005	2018_737640_0021	695
O.Reg 79/10 s. 8. (1)	CO #002	2018_737640_0021	695

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	Légende 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 O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee failed to ensure that prohibited restraints are not used in the home.

A Critical Incident (CI) was submitted that stated on a specific date in 2019, RPN #112 witnessed a prohibited restraint applied on resident #005.

RPN #112 said they observed a prohibited restraint applied on resident #005. The RPN stated it was RN #113 who applied the restraint.

PSW #104 said they had also applied the prohibited restraint on resident #005. The PSW stated they saw the nurse do it the day before. They explained that they were trying to keep the resident safe while attending to other residents as the resident was at high risk for falls.

The DOC explained that their investigation determined that both RN #113 and PSW #104 had applied a prohibited restraint to resident #005.

The licensee failed to ensure that a prohibited restraint was not used in the home for resident #005. [s. 112.]

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 prohibited restraints are not used in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that RPN #112 and RN #119, who had reasonable grounds to suspect that a resident experienced incompetent and/or improper treatment, immediately reported it and the information it was based upon to the Director.

A CI was submitted for resident #005 on a specific date in 2019, that stated that five days prior, RPN #112 witnessed a prohibited restraint applied on the resident.

RPN #112 stated that they witnessed a prohibited restraint applied on resident #005. They stated they did not report the incident until the next time they saw the DOC, which was days later.

RN #119 stated in a separate interview that they saw a prohibited restraint applied on resident #005 when they came in for a night shift. RN #119 stated they never reported this to management. They also could not recall the date of the incident but believed it happened in the last two months.

The DOC stated that RPN #112 informed them five days after the incident, that a prohibited restraint was used on resident #005 and this is when they informed the Director. The DOC explained that their investigation determined that both RN #113 and PSW #104 used the prohibited restraint on resident #005. The DOC acknowledged that it was incompetent and improper treatment of the resident and it was expected to be reported immediately to the Director and was not.

The licensee has failed to ensure that RPN #112 and RN #119, who had reasonable grounds to suspect that resident #005 experienced incompetent and improper treatment, immediately reported it and the information it was based upon to the Director. [s. 24. (1)]

Issued on this 28th day of May, 2019

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

Original report signed by the inspector.