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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 9, 2017	2016_391603_0029	032562-16	Resident Quality Inspection

Licensee/Titulaire de permis

JARLETTE LTD.
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Long-Term Care Home/Foyer de soins de longue durée

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

SYLVIE LAVICTOIRE (603), AMY GEAUVREAU (642), SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 12-16 and December 19-21, 2016.

During the course of the inspection, the inspector(s) directly observed the delivery of resident care, staff to resident interactions, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures and programs and reviewed staff education attendance records.

The following intakes were completed during the inspection: three logs related to critical incidents the home submitted regarding resident falls; three logs related to critical incidents the home submitted regarding alleged resident abuse; and one log related to a complaint related to alleged resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (CDOC), Food Services Supervisor, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist Assistant, Life Enrichment Coordinator, Maintenance Staff, Dietary Aids, Housekeeping Staff, residents, family members and volunteers.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

8 WN(s)
2 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. 2007, c. 8, s. 6 (7).

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. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

During the Resident Quality Inspection (RQI), Inspector #603 observed resident #002's bed to have a specific device.

Inspector #603 interviewed RN #100 who explained that resident #002 was a risk for falls and they had a history of falling out of bed. RN #100 explained that the resident's bed with a specific device was to prevent them from falling out of bed.

Inspector #603 reviewed resident #002's health care record which failed to identify an assessment of the resident's need for a bed with a specific device.

The Inspector interviewed the Administrator and the DOC who explained that the home did not complete any resident assessment to determine the need for a bed with a specific device. The Administrator explained that the home's beds with specific devices were purchased simply to replace others. The DOC explained that when residents are

admitted to the home, there are no specific assessment completed to determine the need for a bed with a specific device. The DOC further explained that the decision to assign a certain bed with a specific device was purely based on availability.

Inspector #603 reviewed the home's policy titled "Resident Rights, Care and Services - Safe and Secure Home - Bedside Rails and Bed Systems" with a revised dated of April 24, 2015. The policy indicated: "The Registered Staff will participate in assessing and planning for the implementation of measures to prevent perceived need for side rails including a comprehensive assessment and the use of a specific device". [s. 6. (2)]

2. During the RQI, Inspector #603 observed resident #003 sitting in a specific chair, beside their bed, which had a specific device.

Inspector #603 interviewed RN #100 who explained that they were surprised that resident #003 had a bed with the specific device and the specific chair was only for comfort.

A review of resident #003's care plan revealed a focus for assistance for mobility and the intervention indicated that the resident was dependent on staff to mobilize in a specific chair in their room and throughout the home. There was no focus or intervention for a bed with a specific device.

A review of the resident's health care record revealed no assessment for the resident's need for a specific chair or a bed with a specific device.

An interview with the Administrator and DOC explained that the home would have no assessment documented around the need for a bed with a specific device and also confirmed that there was no assessment completed for the need of a specific chair. [s. 6. (2)]

3. During the RQI, Inspector #603 observed resident #004 sitting in a specific chair. A few days later, Inspector #603 observed the resident once again sitting a specific chair, and noted that the resident's bed had a specific device.

Inspector #603 interviewed RN #100 who explained that resident #004 needed a specific chair for specified reasons. RN #100 did not know why the resident's bed had a specific device.

A review of resident #004's care plan revealed a focus for assistance for mobility and the intervention included a specific chair. There was no indication for a bed with a specific device.

A review of the resident's health care record revealed no assessment for the resident's need for a specific wheelchair or a bed with a specific device.

An interview with the DOC revealed that the home did not complete an assessment for the need of a specific chair or a bed with a specific device. [s. 6. (2)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During the RQI, Inspector #603 observed resident #002's bed to have a specific device.

The Inspector interviewed RN #100 who explained that resident #002 was a high risk for falls.

A review of the resident's care plan revealed a focus for falls. As part of the interventions, staff were to make sure a specific logo was on the resident's chair.

During the inspection, Inspector #603 observed resident sitting in their specific chair, in the living room. The specified chair did not have the specific logo.

An interview with RN #100 confirmed that there was no specific logo as per resident #002's care plan and demonstrated what the logo should have looked like. [s. 6. (7)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #642 reviewed a Critical Incident (CI) Report submitted to the Director. The CI report described an incident where resident #006 fell, resulting in an injury. The resident's specific chair was approximately five feet away from them.

Inspector #642 reviewed resident's #006 progress notes which revealed that the Resident and Family Services Coordinator had informed the resident's family member that resident #006 was using a specific chair when needed. On further review of

progress notes and assessments, RN #104 had sent a referral to the Restorative Care Coordinator, and after the assessment, it stated that resident #006 required a specific chair for mobility.

A review of the Physiotherapist assessment completed, verified that resident #006 required the use of a specific chair when fatigued.

Inspector #642 reviewed resident's #006 care plan in effect at the time of the fall and the care plan had not been updated to include the resident's use of a specific chair.

During the inspection, the Inspector interviewed and reviewed the documentation with the Physiotherapists Assistant and the Co-Director of Care for resident #006, and they explained that it was the home's expectation that the care plan should have been revised and updated, when the Restorative assessment was completed to include the specific chair as a mode of mobility. [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 the plan of care is based on an assessment of the resident and the resident's needs and preferences; that the care set out in the plan of care is provided to the resident as specified in the plan; and that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD 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. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistive System Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD had been approved by a physician.

According to the LTCHA, 2007, s. 33. (1) a PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themself from the PASD. Under s. 33 (2), a PASD means a personal assistance services device, being a device used to assist a person with a routine activity of living.

During the RQI, Inspector #603 observed resident #004 sitting in a specific chair.

Inspector #603 interviewed RN #100 who explained that resident #004 needed a specific chair for different reasons.

A review of resident #004's care plan revealed a focus for assistance for mobility and the intervention included a specific device.

A review of the resident's health care record revealed no physician order for the specific device.

A second interview with RN #100 explained that the specific chair was a PASD. RN #100 reviewed the resident's health record and did not find a physician order for the specific chair and explained that they should have. [s. 33. (4) 3.]

2. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

According to the LTCHA, 2007, s. 33. (1) a PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themself from the PASD. Under s. 33 (2), a PASD means a personal assistance services device, being a device used to assist a person with a routine activity of living.

During the RQI, Inspector #603 observed resident #004 sitting in a specific chair.

Inspector #603 interviewed RN #100 who explained that resident #004 needed a specific chair for different reasons.

A review of the resident's care plan indicated a focus for assistance for mobility and the intervention included a specific chair.

A review of the resident's health care record revealed no physician order for the specific chair.

An interview with the RN #100 explained that the specific chair was a PASD. RN #100 reviewed the resident's health record and explained that there was no consent for the specific chair. [s. 33. (4) 4.]

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 use of a PASD under subsection (3) to assist a resident with a routine activity of daily living is included in a resident's plan of care only if the use of the PASD has been approved by a physician, and consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

During the inspection, Inspector #603 observed RPN #109 administer medication to resident #007. As part of the medication list, resident #007 was to receive a certain injection. Once the injection was ready, RPN went back to the resident's room and found the resident walking with other residents, with a specific device, in the hallway. RPN #109 approached resident #007 and gave them the injection in the left arm, in front of other residents and staff who were walking by, in the hallway. RPN #109 did not offer the resident a choice as to when or where to give the injection.

Inspector #603 interviewed RPN #109 who explained that the home's expectation was probably not to give an injection in the hallway and to do it more in a discrete area. RPN #109 explained that they usually gave the resident's injection outside of the dining room, which is in the hallway. RPN #109 explained that they never gave the resident a choice as to where to give the injection.

An interview with the Administrator who consulted with the DOC revealed to the Inspector that the home's expectation was to have staff administer injections in a private area and not in the hallway or outside of the dining room. [s. 3. (1) 8.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Inspector #627 reviewed a Critical Incident (CI) Report submitted to the Director on a certain date The CI report alleged staff to resident abuse, 2 days before the incident had been reported to the Director. According to the CI report, the incident was reported by resident #010 to RPN #113 on the day after the incident occurred. RPN #113 then reported the alleged incident to RN #104, who advised the RPN to write a detailed account of the event on a complaint form and submit it to the DOC.

A review of the policy titled "Resident Rights, Care and Services- Abuse", last revised March 26, 2015, indicated that: "Upon awareness of suspected or actual abuse, the individual identifying the abuse will verbally report the situation to the Administrator immediately. If the Administrator was not in the home, report to the DOC. If unable to reach either the Administrator or Director of Care, initiate the MOHLTC Critical Incident report".

During an interview with RN #104, they stated that the home's expectation was that all incidents of abuse or alleged abuse be reported to the Administrator or DOC immediately. RPN #104 confirmed that this was not done.

During an interview with the Inspector, the DOC stated that the home's expectation was that all staff report incidents of abuse or alleged abuse immediately to the Administrator or the DOC. The DOC further stated that an on call schedule was posted for after hours for staff to report all incidents of alleged abuse immediately. The DOC explained that RN #104 should have made them aware of the incident, when they became aware of it as per the home's policy. [s. 20. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

Inspector #627 reviewed a Critical Incident (CI) Report submitted to the Director. The CI report referred to a complaint alleging staff to resident abuse and indicated that RN #100 had been rough with resident #009 while completing a treatment.

A review of RN #100's personnel file revealed a complaint filled out by resident #016's family member. The complaint alleged that RN #100 was loud, disrespectful and had not listened to the family's concerns. As well, a notation indicated that the DOC had asked the family if they wanted this written complaint forwarded to the Ministry of Health and Long-Term Care (MOHLTC) to which the family stated no.

During an interview with the Inspector, the DOC stated that they had not forwarded the complaint to the MOHLTC as the family member had stated this was not necessary.

A review of the policy titled "Resident's Rights, Care and Services- Reporting and Complaints", last revised February 4, 2016, indicated that "When a written complaint is received concerning the care of a resident or the operation of the home, the Administrator shall immediately forward a copy to the Director of Ministry of Health and Long Term Care". [s. 22. (1)]

WN #6: 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 the person who had reasonable grounds to suspect that the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

During the RQI, resident #012 alleged to Inspector #603 that PSW #111 was rude, rough with them, and hurt them. A subsequent interview with resident #012, reiterated that PSW #111 was rough at times and hurt them.

A review of PSW #111's personnel file revealed that the home had received a complaint from resident #012 regarding PSW #111. The home did an investigation, and the resident confirmed their complaint regarding PSW #111 and requested PSW #111 not provide care to them. The home concluded that PSW #111 should not give personal care to resident #012.

According to the LTCHA 2007, physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

An interview with the Co-Director of Care revealed that they did not report this resident complaint to the Director as they did not suspect abuse. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM), if any, and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

During the RQI, resident #012 alleged to Inspector #603 that PSW #111 was rude, rough, and hurt them. A subsequent interview with resident #012 reiterated that PSW #111 was rough at times and hurt them.

A review of PSW #111's personnel file revealed that the home had received a complaint from resident #012 regarding PSW #111. The home did an investigation and the resident confirmed their complaint regarding PSW #111 and requested PSW #111 not provide care to them. The home concluded that PSW #111 should not give personal care to resident #012.

According to the LTCHA 2007, physical abuse is defined as the use of physical force by

anyone other than a resident that causes physical injury or pain.

An interview with the Co-Director of Care revealed that they did not report this alleged resident abuse complaint to the next of kin (daughter), because they did not suspect abuse and they felt that the resident was their own POA. [s. 97. (1) (a)]

2. Inspector #627 reviewed a Critical Incident (CI) Report submitted to the Director. The CI report alleged staff to resident abuse two days before the incident was sent to the Director. According to the CI report, the incident was reported by resident #010 to RPN #113, the day after the incident. RPN #113 then reported the alleged incident to RN #104, who advised the RPN to write a detailed account of the event on a complaint form and submit it to the DOC.

Inspector #627 reviewed resident #010's progress notes which indicated that the day after the incident, the resident approached a staff member and appeared upset. The resident had informed the staff member that they had a terrible evening/night and then voiced their concerns that they had with a staff member.

During an interview with RN #104, they stated that they had not contacted resident #010's SDM to notify them of the alleged abuse.

During an interview with the DOC, they stated that they only contacted resident #010's SDM when they became aware of the incident, which was two days after the incident occurred. [s. 97. (1) (a)]

3. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM), if any, and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

During the Resident Quality Inspection, resident #012 alleged that PSW #111 was rude, rough with them, and hurt them. A subsequent interview with resident #012, reiterated that PSW #111 was rough at times and hurt them.

According to the LTCHA 2007, physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

A review of PSW #111's personnel file revealed that the home had received a complaint from resident #012 regarding PSW #111. The home did an investigation and the resident confirmed their complaint regarding PSW #111 and requested PSW #111 not care for them. The home concluded that PSW #111 should not give personal care to resident #012.

Inspector #603 reviewed the resident's health care record and in the profile, the resident's specific family member was written as their alternate contact, next of kin, and the resident's primary contact for health care.

An interview with the Co-Director of Care revealed that they did not report this resident complaint to the next of kin (family member) because they did not suspect abuse and they felt that the resident was their own POA. [s. 97. (1) (a)]

WN #8: 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. The licensee has failed to ensure that the policy to minimize restraining of residents addressed the duties and responsibilities of the staff, including who has the authority to apply or release a physical device.

Inspector #603 reviewed the home's policy titled "Resident Rights, Care and Services - Minimizing of Restraining" revised February 18, 2016, which included the Personal Assistive Service Devices (PASDs), Documentation of Restraint Use, and Consent and noted that the policy did not address the duties and responsibilities of the staff, including who had the authority to apply or release a physical device.

The Inspector interviewed the Administrator who reviewed the policy and agreed with the Inspector that this information was missing. [s. 109. (b) (i)]

2. The licensee has failed to ensure that the duties and responsibilities of the staff, including ensuring that all appropriate staff are aware at all times of when a resident is being restrained by a physical device.

Inspector #603 reviewed the home's policy titled "Resident Rights, Care and Services - Minimizing of Restraining" revised February 18, 2016, which included the Personal Assistive Service Devices (PASDs), Documentation of Restraint Use, and Consent and noted that the policy did not address the the duties and responsibilities of the staff, including ensuring that all appropriate staff are aware at all times of when a resident is being restrained by a physical device.

The Inspector interviewed the Administrator who reviewed the policy and agreed with the Inspector that this information was missing. [s. 109. (b) (ii)]

Issued on this 10th day of January, 2017

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

Original report signed by the inspector.