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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 5, 2014	2014_199161_0009	O-000229-14	Resident Quality Inspection

Licensee/Titulaire de permis

VILLA MARCONI LONG TERM CARE CENTER
1026 BASELINE ROAD, OTTAWA, ON, K2C-0A6

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

VILLA MARCONI
1026 BASELINE ROAD, OTTAWA, ON, K2C-0A6

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

KATHLEEN SMID (161), ANGELE ALBERT-RITCHIE (545), RUZICA SUBOTIC-HOWELL (548), SUSAN WENDT (546)

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): April 3, 4, 7, 8, 9, 10, 2014.

During the course of the inspection, the inspector(s) also conducted two Critical Incident inspections Log #O-000276-14 and Log #O-000289-14.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members,Volunteers, two members of Residents' Council, President of Family Council, Personal Support Workers (PSW), Health Care Aides, Registered Nurses (RN), Registered Practical Nurses (RPN), Recreation and Volunteer Coordinator, a Dietary Aide, Housekeeper, Restorative Aide, Activity Aide, Environmental Service Supervisor, Food Service Supervisor, RAI Coordinator, Resident Care and Informatics, Clinical Coordinator, Director of Care and the Administrator.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, staff work routines, a 3 week menu, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed a medication pass, observed two meal services, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to comply with O.Reg 79/10 s.50 (2) a (ii) in that the Home failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon return from the hospital.

Resident #9631 was hospitalized in 2013 and returned to the LTCH with a stage 4 pressure ulcer. The Home's skin and wound program's policy #NM-II-S010 indicates that upon return from hospital, a head-to-toe assessment is to be conducted and for assessment of skin-related risk, the Braden Scale is to be used. Upon Resident #9361's return from hospital 2013, there was no evidence in the Resident's health record that a Braden Scale assessment was completed for this resident. [s. 50. (2) (a) (ii)]

2. The licensee failed to comply with O.Reg 79/10 s.50 (2) b (ii) and (iv) in that the Home failed to ensure that a resident exhibiting altered skin integrity,

• Received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, as required and
• is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On April 7, 2014, the DOC confirmed to LTCH Inspector #546 that:
• the Home's current skin and wound care program's policies and procedures (dated February 2009) were being followed by all registered staff;
• Wound Tracker (Push Tool 3.0) was the only tool where wound documentation is entered to measure the wound, thereby providing an indication of the improvement or deterioration in pressure ulcer healing, as per the Home's skin and wound program's policy # NM-II-W020 (Wound Care) and that,
• Wound Tracker must be completed on each wound at least once a week as per the Home's skin and wound care program's policy # NM-II-W020 (Wound Care).

The home's Wound Tracker form identifies the wound type details (e.g. wound type, acquired type and status), the wound site (e.g. wound image, assessment PUSH score, dimensions, stage and base), the tissue type and pain (e.g. type of exudate, amount of exudate, pain and tissue type), the presence of infection, pathogen (e.g. type of infection), treatment and notes. Weekly wound assessments are to be documented in the Wound Tracker as per the Home's skin and wound program's policy #NM-II-W020.

Resident #9361's health care record was reviewed by LTCH Inspector #546 and the following were found:
• Between a specified date in 2013 to a specified date in 2014, the Resident's Stage 4 pressure ulcer should have been assessed on a weekly basis for 22 weeks. A review of the Resident's Wound Tracker indicated that weekly assessments were completed 13 /22 weeks.
• Over a seventeen (17) week period, between a specified date in 2013 to a specified date in 2014, LTCH Inspector #546 noted fourteen (14) entries written by registered staff in Resident #9361's progress notes, indicating that the Resident's Stage 4 pressure ulcer was foul smelling with a purulent exudate.

• On a specified date in 2014, a swab for culture and sensitivity was done on the Stage 4 pressure ulcer of Resident #9361. This information was not recorded in the Resident's Wound Tracker. The results of this swab, contained in the lab report, indicated a bacterial infection. On a specified date in 2014, RPN #S103 notified the

attending physician of the lab report results; RPN #S103 recorded the physician's prescription of antibiotics for Resident #9361's infected wound.

As such, the licensee failed to ensure that Resident #9361's received (1) immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection; and (2) weekly reassessments of the Resident's Stage 4 pressure ulcer by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (ii)]

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 a resident at risk of altered skin integrity receive a skin assessment by a member of the registered nursing staff upon return from the hospital; to ensure that a resident exhibiting altered skin integrity receives immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, as required and, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. As per O. Reg. 79/10, s. 219 (1) the intervals for the purposes of subsection 76 (4) (refer to below) of the Act are annual intervals .

The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 76 (4) in that the licensee did not ensure in 2013 that the persons who have received training under subsection (2),receive training in the following areas on an annual interval including: (1) Residents' Bill of Rights, (2) long-term care home's mission statement, (3) long-term care home's policy to promote zero tolerance of abuse and neglect of residents, (4)duty under section 24 to make mandatory reports, (5) protections afforded by section 26 (Whistle Blowing), (6) long-term care home's policy to minimize the restraining of residents.

On April 9, 2014 the Director of Care in the presence of the home's Administrator, indicated to inspector #161 that although the home had not trained all direct care staff in minimizing the restraining of residents, all the annual training required by the Ministry of Health and Long Term Care, was done in 2013.

On April 9, 2014, Inspector #545 asked the Clinical Coordinator to provide documentation of all Education provided to the home's staff in 2013, including staff attendance. Unit Clerk S#128, at the request of the Clinical Coordinator provided Inspector #545 a Staff Education Binder for 2013. In reviewing the Staff Education Binder for 2013, documentation regarding staff attendance for the mandatory training for following areas were not found: (1) Residents' Bill of Rights, (2) long-term care home's policy to promote zero tolerance of abuse and neglect of residents, (3) duty under section 24 to make mandatory reports, (4) protections afforded by section 26 (Whistle Blowing), (5) long-term care home's policy to minimize the restraining of residents.

On April 10, 2014 during an interview with the Director of Care, Resident Care/Coordinator and the Administrator, the DOC indicated to the inspector that in 2013, some of the mandatory training that was provided in 2013 was recorded electronically on an Excel spreadsheet for all staff. Hence, although staff attendance was not recorded in the Staff Education Binder, their attendance would have been recorded in the Excel spreadsheet. In reviewing the 2013 Excel spreadsheet that the DOC provided, there was no evidence that the following areas of annual mandatory training were done including: (1) Residents' Bill of Rights, (2) long-term care home's policy to promote zero tolerance of abuse and neglect of residents, (3) duty under section 24 to make mandatory reports, (4) protections afforded by section 26 (Whistle Blowing), (5) long-term care home's policy to minimize the restraining of residents.

On April 10, 2014 upon review of the Excel spreadsheet the DOC provided, he confirmed that the staff had not received mandatory training in 2013 in the above 5 stated areas. Furthermore, slightly greater than half (58%) of the staff in 2013 received mandatory training in Fire prevention and safety and Emergency and evacuation procedures. [s. 76. (4)]

2. As per as per O. Reg. 79/10 s. 221. (1) for the purposes of paragraph 6 of subsection 76 (7) of the Act, subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act (refer to below).

The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 76 (7) in that the licensee did not ensure in 2013 that additional training was provided to direct care staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out including: (1) Abuse recognition and prevention, (2) Mental health issues, including caring for persons with dementia,

(3) How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations, (4) Palliative care.

On April 10, 2014 during an interview with the Director of Care, Resident Care/Coordinator and the Administrator, the DOC and the Resident Care Coordinator indicated that in 2013, direct care staff did not receive training in (1) Abuse recognition and prevention, (2) How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations whereby 26% of staff received training, nor 3) Palliative care. In the area of Mental health issues, including caring for persons with dementia, 2 out of 97 staff were trained in 2013.

As such, annual training in the areas required under subsection 76 (7) of the Act was not provided to all direct care staff in 2013, including: Abuse recognition and prevention, Mental health issues, including caring for persons with dementia, How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations, and Palliative care. [s. 76. (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 to ensure that all staff of the home receive annual training including: (1) Residents' Bill of Rights, (2) long-term care home's mission statement, (3) long-term care home's policy to promote zero tolerance of abuse and neglect of residents, (4)duty under section 24 to make mandatory reports, (5) protections afforded by section 26 (Whistle Blowing), (6) long-term care home's policy to minimize the restraining of residents. As well to ensure that all direct care staff receive annual training (7) Abuse recognition and prevention, (8) Mental health issues, including caring for persons with dementia, (9) Behaviour management, (10) How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations, (11) Palliative care and (12) Any other areas provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s.229. (10) 4. in that the home's employees are not screened for tuberculosis in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

As of November 1, 2013 the home employs a total of 150 staff at the home as indicated on the form titled: Seasonal Influenza Immunization Rates at Long-Term Care Homes received from the homes Administrator on April 10, 2014.

On April 10, 2014 the Administrator provided to inspector #548 the immunization records of employees screened for tuberculosis. The immunization records were reviewed and a total of 4/150 employees employed at the home have been screened for tuberculosis.

On April 10, 2014 the Administrator and the DOC confirmed that not all staff has been screened for tuberculosis. The DOC further stated that it is not a requirement of the home to screen staff for tuberculosis upon hiring. [s. 229. (10) 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 to ensure that all current employees and future employees are screened for tuberculosis in accordance with evidence-based practices and, if there are non, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: 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. (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).

Findings/Faits saillants :

1. The licensee had failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6. (7) to ensure that the care set out in the plan of care is provided to the Resident as specified in the plan.

On a specified date in 2014 the Director was notified via the Critical Incident Report System that on a specified date in 2014 the Substitute Decision Maker for Resident #003 brought forward concerns to the home regarding care provided to Resident #003 by PSW #S129. These concerns included on-going incidents of PSW #S129 transferring Resident #003 using a Sara mechanical lift independently and causing the Resident to be fearful of being hurt.

On April 9, 2014 inspector #161 interviewed Resident #003. The Resident indicated that PSW #S129 transfers her/him alone with the Sara mechanical lift. Resident #003 is afraid that she/he will be hurt as PSW #S129 is rough during transfers, hitting the Resident's arms with the mechanical lift. On April 14, 2014 discussion with the Resident's Substitute Decision Maker who verified that Resident #003 is afraid of being hurt and that PSW #S129 always transfers Resident #003 with the Sara mechanical lift without the assistance of another staff member.

On April 9, 2014 Inspector #161 reviewed Resident #003's most recent plan of care which indicated that Resident #003 was unable to safely transfer independently due to back pain nor unable to weight bear. Resident #003 was a two+ person physical assist and that staff was to use the Sara mechanical lift for all transfers, including for toileting as required.

On April 9, 2014 Inspector #161 asked for and received from the DOC a document for a specified date in 2014 titled: "Resident and Family Complaint Investigation Form # Nsg 04-02". There is a notation in this document that indicates PSW #S129 confirmed on a specified date in 2014, in the presence of the DOC, CUPE representative and Resident Care Coordinator that she independently transfers Resident #003 using the Sara mechanical lift. PSW #S129 was unavailable at the time of this inspection to be interviewed by Inspector #161. [s. 6. (7)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 r.17 (1)(f) in that the licensee did not ensure that the home is equipped with a resident-staff communication and response system that clearly indicates when activated, where the signal is coming from.

In October 2013 the home installed a SARA 100 resident-staff communication and response system. When a pull cord in the Resident's room or bathroom is activated, a signal is sent to a pager which each Personal Support Worker carries. The pager emits an audio alarm and displays the resident's room number.

On April 7, 2014 at 11:07 Inspectors #161 and #545 borrowed a pager from a Personal Support Worker on the second floor. The inspectors proceeded to 10 Resident rooms and activated both the pull cords in the Resident's rooms and in their respective bathrooms. In 2/10 Resident rooms, the pager did not emit an audio alarm nor display the Resident's room number. This process was repeated on the first floor. In 2/10 Resident rooms, the pager did not emit an audio alarm nor display the Resident's room number.

On April 7, 2014 this information was conveyed to the home's Executive Director. He immediately took corrective action to ensure that the resident-staff communication and response system clearly indicates when activated, where the signal is coming from. On April 8, 2014 Inspector #161 re-checked the affected rooms and the pagers emitted an audio alarm and displayed the Resident' room numbers. [s. 17. (1) (f)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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. 2007, c. 8, s. 31 (2).

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. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee had failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 31. (2) 4 in that two Resident's restraint plans of care did not include an order by the physician or the registered nurse in the extended class for the application of rear locked belt restraint when sitting in their wheelchair.

Resident #9337:
On a specified date in 2014 Inspector #545 observed Resident #9337 sitting in their wheelchair with a table top which was locked at the rear of their wheelchair. Resident #9337 showed Inspector #545 that she/he was unable to reach the clasp at the back of their wheelchair to release the table top locked at the rear of their wheelchair.

In a review of the most recent plan of care for Resident #9337, it was indicated that this Resident was at high risk for falls and had impaired judgment. A rear locked table top restraint is required when this Resident sits in their wheelchair to ensure their safety and prevent injury.

In reviewing Resident #9337's health care record, RPN #S110, the Clinical Coordinator and the Director of Care were unable to locate a written order from a physician or a registered nurse in the extended class for the rear locked table top restraint used daily for Resident #9337 when sitting in their wheelchair.

Resident #9363:
On two specified dates in 2014 during breakfast, Inspector #545 observed Resident #9363 sitting in their wheelchair with a table top locked at the rear of their wheelchair.

On a specified date in 2014, Resident #9363 indicated to inspector #545 that she/he requested staff to lock the table top behind her/his wheelchair to keep it in place and prevent it from falling off the wheelchair. When asked if she/he could remove the rear locked restraint, Resident #9363 indicated she/he was not able to remove it due to physical limitations.

In a review of the most recent plan of care for Resident #9363, it was indicated that this Resident was at high risk for falls related to impaired balance, cognitive impairment and anxiety. Resident #9363 requires a lap belt and table top when sitting in the wheelchair. There was no information in the plan of care regarding the rear locked table top.

In reviewing Resident #9363's health care record, the Clinical Coordinator was unable to provide a written order from a physician or a registered nurse in the extended class for the rear locked table top restraint used daily for Resident #9363 when up in the wheelchair.

As such, the restraint plans of care for Resident #9337 and Resident #9363's do not include an order for rear locked table top restraints when sitting in their wheelchairs. [s. 31. (2) 4.]

2. The licensee had failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 31. (2) 5 in that two Residents' restraint plans of care did not include a consent by their substitute decision makers (SDM) for the application of rear locked table top restraint when sitting in their wheelchairs.

In an interview with the DOC on April 9, 2014 he indicated that consent from the Resident's SDM's was not requested for Resident #9337 and Resident #9363 because staff understood that the intent of the rear locked table top restraint was a Personal Assistance Services Device (PASD). Staff did not consider that Resident #9337 and Resident #9363 were unable to release their rear locked table tops. The DOC indicated that the rear locked table tops were a restraint for Resident #9337 and Resident #9363 because both Residents were unable to release their rear locked table tops.

In reviewing Resident #9337 and Resident #9363's health care records, the Clinical Coordinator was unable to provide a signed consent from the Residents SDM's for

their rear locked table top restraints used when they are sitting in their wheelchairs.

As such, the restraint plans of care for Resident #9337 and Resident #9363's did not include a consent by their substitute decision makers for the daily use of rear locked table top restraint when they are sitting in their wheelchairs. [s. 31. (2) 5.]

Issued on this 6th day of May, 2014

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

KATHLEEN SMITH