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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 3, 2013	2013_211106_0037	S-000359-13	Other

Licensee/Titulaire de permis

The West Nipissing General Hospital
725 Coursol, STURGEON FALLS, ON, P2B-2Y6

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

THE WEST NIPISSING GENERAL HOSPITAL
725 COURSOL, STURGEON FALLS, ON, P2B-2Y6

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): October 23, 2013

The following log was reviewed as part of this inspection: Log # S-000359-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Dietary Manager, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), and Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed a meal service, observed care provided to residents in the home and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

Residents' Council

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

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. On October 23, 2013, inspector observed resident #001 sitting in their chair with a restraint applied. The inspector reviewed the home's policy # 605H-18, titled "Restraints (Use Of)", which indicated that residents are only to be restrained by a physical device if it is in their plan of care and the plan of care, includes the following:
-"The resident is monitored while restrained"
-"The resident is released and repositioned, while restrained"
-"The resident's condition is reassessed and the effectiveness of the restraining evaluated every shift"
-"The resident is restrained only for as long as is necessary to address the risk"
-"The method of restraining used is to be discontinued if, as a result of the reassessment it is determined that an alternative to the restraint, or a less restrictive method would address the risk"

The inspector reviewed resident #001's plan of care document and none of the above information was found, nor was any information found regarding the resident's applied restraint. The licensee failed to ensure that if a resident is restrained by a physical device the restraining of the resident is included in the resident's plan of care. [s. 31. (1)]

2. On October 23, 2013, resident #001 was observed by the inspector, sitting in their chair with a restraint applied. Inspector reviewed the home's policy # 605H-18, titled "Restraints (Use of)". This policy indicated that, "If a verbal consent is obtained, document who gave the consent, written consent needs to be obtained within 24 hours."

A RPN reported to the inspector, that the staff will call the family for consent of the restraint prior to getting the doctor's order, but they do not document this anywhere. This same RPN then reviewed resident #001's chart with the inspector and no documentation regarding consent for the restraint was found.

The licensee failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if the following is satisfied, 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. [s. 31. (2) 5.]

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, if resident #001 is restrained by a physical device, the restraining of resident #001 is included in their plan of care and to ensure that the restraining of resident #001 by a physical device is included in their plan of care only if the following is satisfied, the restraining of resident #001 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. On October 23, 2013, management staff member #S-100 reported that the home has not shared the results of the most recent satisfaction survey with the Residents' Council. The licensee failed to ensure that the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice. [s. 85. (4) (a)]

Issued on this 6th day of December, 2013

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