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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 4, 2015	2015_264609_0057	029576-15	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE TOWN OF KIRKLAND LAKE
3 KIRKLAND STREET WEST POSTAL BAG 1757 KIRKLAND LAKE ON P2N 3P4

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

TECK PIONEER RESIDENCE
145A GOVERNMENT ROAD EAST POSTAL BAG SERVICE 3800 KIRKLAND LAKE ON P2N 3P4

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

CHAD CAMPS (609), FRANCA MCMILLAN (544), GILLIAN CHAMBERLIN (593), 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): November 16, 17, 18, 19, 20, 23, 24, 25, 26, 2015

Concurrent follow up and Critical Incident inspections were also conducted during the Resident Quality Inspection (RQI).

During the course of the inspection, the inspector(s) spoke with the licensee, the Administrator/Director of Care, the Assistant Director of Care (ADOC), the Clinical Coordinator, the Activity Coordinator, the Business Office Coordinator, the Maintenance Coordinator, the Resident Assessment Instrument (RAI) Coordinator, two Registered Nurses (RN), three Registered Practical Nurses (RPN), six Personal Support Workers (PSW), one Restorative Care Aide (RCA), one Dietary Aide and one Substitute Decision Maker (SDM) for a resident of the home.

The inspector(s) also toured the home, reviewed the home's policies and procedures, clinical records, plans of care, internal investigation notes, employee human resource files and Resident Council minutes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

10 WN(s)
5 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. 15. (2)	CO #001	2015_380593_0013	593

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. 7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent. 2007, c. 8, s. 7.

Findings/Faits saillants :

1. The licensee failed to ensure that no assessment of a resident's requirements and no change to the provision of care or services was provided to a resident without consent.

A review of the home's communications records revealed an identified number of residents of the home had a specified intervention discontinued. All identified residents had active Substitute Decision Makers (SDM).

An interview with the SDM for an identified resident revealed they were not notified of the discontinuation of the specified intervention.

An interview with the ADOC confirmed that it was the expectation of the home that no assessment of a resident's requirements and no change to the provision of care was to occur without consent, that in the case of the specified intervention for the identified residents with active SDMs no consent was obtained before proceeding and should have been. [s. 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 no assessment of a resident's requirements and no care or services will be provided to a resident without consent, 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. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A Critical Incident (CI) report was submitted to the Ministry indicating that an identified resident sustained an injury from a fall.

A review of the home's policy titled "Falls Prevention and Management Program" last reviewed September 2015 indicated that when a resident had fallen, the resident would be assessed regarding the nature of the fall and associated consequences, the cause of the fall, the post fall care management needs and that the post fall assessments would facilitate in identifying contributing factors to prevent another occurrence.

A review of the clinical record for the identified resident revealed that a post fall assessment was not conducted after the resident fell.

An interview with registered staff confirmed that they were aware that a post fall assessment was to be completed after each resident fall and that this did not occur for the cited fall.

An interview with the Administrator confirmed that it was the expectation of the home that a post fall assessment was to be completed on all residents who have fallen, that for the identified fall this did not occur and should have. [s. 8. (1)]

2. A review of the clinical record for an identified resident revealed they exhibited responsive behaviours from admission to present day.

A review of the home's policy titled "Responsive Behaviours" last revised August 2015 revealed:

a) Aggressive Behavioural Charting (ABC) was to be used to document any responsive behaviours.
b) Resident responsive behaviours were to be assessed on admission, quarterly and at any time when the resident's care needs changed or care set out in the plan was no longer necessary.
c) The plan of care should establish resident-focused, interdisciplinary goals and strategies for residents with responsive behaviours.

d) Residents experiencing responsive behaviours were to be noted on the RED BOARD to ensure heightened monitoring by staff.
e) Any incidents of responsive behaviours were to be documented in the Risk management tab in Point Click Care.

Observations of the home's RED BOARD revealed no mention of the identified resident.

A review of the clinical record for the identified resident for a specified time frame revealed multiple episodes of responsive behaviour lacking documentation regarding the evaluation of the staff interventions and the resident's responses to the interventions.

A review of the clinical record also revealed that no ABC documentation for the identified resident was initiated and no other assessments or re-assessments were completed regarding the responsive behaviour of the resident.

A review of the plan of care for the identified resident revealed no focus, goals, interventions or potential triggers identified regarding the management of the identified responsive behaviours.

A review of Risk Management for a specified time frame revealed no documentation of the responsive behaviours of the resident.

An interview with the ADOC confirmed that it was the expectation of the home that the responsive behaviours policy be complied with, that in the case of the responsive behaviours of the identified resident this did not occur and should have. [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 to ensure that the Responsive Behaviour policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of the home's policy titled "Falls Prevention and Management Program" indicated that registered staff were to complete a post fall screen for Resident/Environmental Factors.

A review of the clinical record for an identified resident revealed multiple falls had occurred and no post fall screen was completed.

A review of the clinical record for another identified resident again revealed multiple falls had occurred and no post fall screen was completed. A total of 80 per cent of the falls reviewed did not have a post fall screen completed.

An interview with the Administrator confirmed that it was the expectation of the home that a post fall screen was to be completed after each resident fall, that in the case of the cited falls this did not occur and should have. [s. 49. (2)]

2. A Critical Incident (CI) report was submitted to the Ministry which indicated that on a specified day while care was being performed an identified resident fell.

A review of the home's policy titled "Falls Prevention and Management Program" last reviewed September 2015 revealed that when a resident had fallen, the resident would be assessed regarding the nature of the fall and associated consequences, the cause of the fall and the post fall care management needs and that post fall assessments would facilitate in identifying contributing factors to prevent reoccurrence.

A review of the clinical record for the identified resident revealed no post fall assessment was conducted after the resident fell.

An interview with registered staff revealed that they were aware that a post fall assessment was to be completed and that one was not completed after the identified resident fell.

An interview with the Administrator confirmed that it was the expectation of the home that a post fall assessment was to be completed after each fall, that in the case of the cited fall by the identified resident this did not occur and should have. [s. 49. (2)]

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 when a resident has fallen, the resident will be assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours strategies were developed and implemented to respond to these behaviours, where possible.

A review of the clinical record for an identified resident revealed they exhibited responsive behaviours from admission to present day.

A review of the admission RAI-Minimum Data Set (MDS) for the identified resident revealed that behavioural symptoms were present. The subsequent RAI-MDS identified that the behavioural symptoms of the resident had increased.

A review of the clinical record for a specified time frame indicated that the identified resident exhibited aggressive responsive behaviours and could not substantiate that Aggressive Behaviour Charting (ABC) used for documentation of responsive behaviours or that the Daily Observation Sheet (DOS) used for heightened monitoring of responsive behaviours was ever initiated for the identified resident.

A review of the care plan for the identified resident revealed that no focus, goals, interventions or potential triggers were identified regarding the management of the responsive behaviours.

An interview with the RAI-Coordinator confirmed that it was the expectation of the home that DOS and ABC strategies should be implemented when responsive behaviour episodes occur as well as be identified in the resident's care plan, that in the case of the multiple responsive behaviour episodes of the identified resident this did not occur and should have. [s. 53. (4) (b)]

2. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of the clinical record for an identified resident for a specified time frame revealed multiple episodes where the resident exhibited aggressive responsive behaviour. 80 per cent of the episodes did not have documentation regarding the evaluation of the staff interventions or the responses to the interventions by the resident.

There was no other documentation in the clinical record for the identified resident to

support that any assessments and re-assessments were completed regarding the responsive behaviours of the resident.

An interview with the RAI-Coordinator confirmed that it was the expectation of the home that staff document the evaluation of interventions to responsive behaviours as well as the responses to the interventions by the resident, that in the case of the eight episodes of responsive behaviour cited this did not occur and should have. [s. 53. (4) (c)]

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, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible; and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and that complies with manufacturer's instructions for the storage of the drugs.

Observations on November 18, 2015, in each of the three med rooms in the home revealed insulin was being stored in refrigerators with no thermometer to monitor the temperature.

A review of the manufacturer's instructions for Novorapid insulin located in the refrigerator revealed it was to be stored in a temperature range between two and 10 degrees Celsius to maintain efficacy. Other insulins located in the med room refrigerators were to be stored between two and eight degrees Celsius.

An interview with the Administrator confirmed that it was the expectation of the home that medications were to be stored as per manufacturer's instructions, that in the case of the unmonitored temperatures of insulins there was no way to ensure the insulins were stored as per manufacturer's instructions and should be. [s. 129. (1) (a)]

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 drugs are stored in an area that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #6: 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. (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 has failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

Observations of an identified resident at specified times revealed the resident positioned in a specified way while personal support staff assisted with feeding.

A review of the plan of care for the identified resident revealed the resident was at risk of aspiration. There was no direction in the plan of care related to the specified way the resident was positioned.

An interview with the RAI-Coordinator confirmed that it was the expectation of the home that the plan of care for each resident set out clear direction to staff and others who provide direct care, that in the case of the lack of direction to staff related to the specified position of the resident at specified times, this did not occur and should have. [s. 6. (1) (c)]

2. A Critical Incident (CI) report was submitted to the Ministry which indicated that on a specified day while care was being performed an identified resident fell.

A review of the current electronic plan of care for the identified resident indicated the resident required one person assistance with transfers.

A review of paper copy of the plan of care for the identified resident indicated the resident required two person assistance for transfers using a specified piece of equipment.

A review of electronic Kardex for the identified resident indicated the resident required two person assistance for transfers using the resident's adaptive aid.

An interview with personal support staff revealed personal support staff usually access the Kardex as they usually do not have time to read the full plan of care.

An interview with the Administrator confirmed that it was the expectation of the home that the plan of care set out clear directions to staff and others who provide direct care to the resident, that in the case of the conflicting instructions in the electronic plan of care, paper plan of care and Kardex related to transfers for an identified resident, this did not occur and should have. [s. 6. (1) (c)]

3. 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.

A review of the clinical record for an identified resident revealed they were prescribed a specified intervention. The review of the clinical record revealed no documentation to support that the treatment was being completed as ordered by the physician.

An interview with restorative care staff revealed they assisted the identified resident with the specified treatment some of the time.

An interview with the identified resident revealed they did not perform the treatment as ordered and confirmed that staff did not follow up with them to assist or ensure the treatment was completed.

An interview with the ADOC confirmed that staff should have followed up with the resident to ensure monitoring of the resident's response to the treatment and that the treatment was completed as ordered by the physician. The ADOC confirmed that it was the expectation of the home that care set out in the plan of care was provided to the resident as specified in the plan, that in the case of the specified post hospitalization treatment for the identified resident, this did not occur and should have. [s. 6. (7)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that interventions were implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's responsive behaviours that minimize the risk of altercations and potentially harmful interactions between and among residents.

During a previous inspection, #2015-391603-0030, a compliance order was issued related to this legislation with a compliance date of December 18, 2015. This finding further supports the current outstanding compliance order related to r. 55.(a).

A Critical Incident Report was submitted to the Ministry which indicated that an identified resident had an altercation with another identified resident resulting in an injury to one of the residents.

A review of the clinical record for a specified time frame for the identified resident revealed multiple incidents of responsive behaviour.

A review of the clinical record for the identified resident revealed they were begun on a medical intervention and that the responsive behaviours continued after the medical intervention was started.

A review of the home’s policy titled “Responsive Behaviours” last revised August 2015 indicated that staff were to use DOS (Daily Observation Sheet) charting when monitoring a resident when there has been an escalation in responsive behaviors. The policy also indicated that specialized service referrals such as BSO (Behavioural Supports Ontario) were appropriate when there was an imminent risk of harm.

A review of the clinical record revealed DOS charting and a BSO referral was initiated only after multiple incidents of responsive behaviours.

An interview with the Administrator confirmed that it was the expectation of the home that DOS charting and the accompanying resident checks every 30 minutes as well as a BSO referral should have been implemented sooner to minimize the risk of altercations and the potentially harmful interactions of the identified resident and that this did not occur. [s. 55. (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Residents' Council had advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1) the licensee responded in writing within 10 days of receiving the advice.

A review of the Resident Council minutes for September, October and November 2015 found multiple concerns and recommendations from the Resident Council to the licensee of the home. There was no written response available from the licensee to the Resident Council regarding this advice.

An interview with the Activity Coordinator who sits as the home's representative to the Resident Council revealed that the licensee responded mostly verbally and not in writing to the concerns and recommendations raised during Resident Council meetings. [s. 57. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a weight monitoring system measured and recorded each resident's height on admission and annually.

A review of the clinical records of 40 residents revealed eight or 20 per cent did not have a height recorded within 365 days of the last measurement.

An interview with the RAI-Coordinator confirmed that it was the expectation of the home that heights were taken on admission and annually thereafter, that in the case of the eight residents cited, annual heights should have been taken and that this did not occur. [s. 68. (2) (e) (ii)]

WN #10: 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 has failed to ensure any device with locks that can only be released by a separate device, such as a key or magnet was not used within the home.

Observations of an identified resident on a particular day revealed the use of a specific device.

An interview with the Administrator revealed that there were other identified residents in the home that used the same device.

A review of the home's policy titled "Use of Restraints" last review date September 2015 outlined the prohibited devices in the home that limit movement which included "any device with locks that can only be released by a separate device".

In an interview with the Administrator a review of the Regulation and the home's policy on prohibited devices was conducted. The Administrator confirmed that it was the expectation of the home that prohibited devices should not have been used, that in the case of the specified intervention, the home was not in compliance with the Regulation or the home's policy and should be. [s. 112. 3.]

Issued on this 4th day of December, 2015

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

Original report signed by the inspector.