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
Jan 31, 2013	2013_188168_0001	H-001618-12, H-00709-12	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 17 and 18, 2013.

This inspection involved the review of two Critical Incident reports, logged as H-00709-12 and H-001618-12.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DOC), the Assistant Director of Nursing (ADOC), registered and unregulated care providers and residents.

During the course of the inspection, the inspector(s) reviewed the clinical health record of two identified individuals, reviewed relevant policy and procedures and staff training records and observed the provision of care provided to residents.

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

Personal Support Services

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.)	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. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee of a long-term care home did not ensure that resident #001 was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

Resident #001 was observed on January 17, 2013, in the wheelchair with a locked table top in place. Registered and unregulated staff interviewed confirmed that the table top was a device to restrain the resident.

The use of the table top restraint was not in accordance with section 31 (or section 36) as the resident did not have an order for the device, nor were the reassessments conducted consistent with the restraint in use.

On January 17, 2013, the resident had an order from the physician for the use of a seatbelt in the wheelchair only, not an order for a table top restraint. The resident began to use a table top restraint in the summer of 2012.

Staff reassess the residents need for a restraint three times a day and record this information on the Medication Administration Record (MAR). The MAR sheets for December 2012 and January 2013 indicate that staff have reassessed the need for the resident to be restrained with both a seatbelt and a table top when in the wheelchair. Resident #001 uses only a table top restraint when in the chair.

Interview with registered staff confirmed that the resident did not have an order in place for the use of a table top restraint or reassessments completed reflective of the actual device in use. [s. 30. (1)]

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 resident is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36 of the Act, to be implemented voluntarily.

Issued on this 31st day of January, 2013

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