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
Aug 25, 2016	2016_280541_0022	013444-16	Resident Quality Inspection

Licensee/Titulaire de permis

CARVETH NURSING HOME LIMITED
375 JAMES STREET GANANOQUE ON K7G 2Z1

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

CARVETH CARE CENTRE
375 JAMES STREET GANANOQUE ON K7G 2Z1

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

AMBER LAM (541), HEATH HEFFERNAN (622)

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): August 22-24, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care, the Activation Director, the RAI coordinator, Registered Nurses, Registered Practical Nurses, the Presidents of the Resident and Family Councils, family members and residents. In addition the inspectors observed a medication administration, reviewed relevant policies and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents is complied with.

On a specified date and time, this inspector noted resident #041 to be sitting in a wheelchair self-propelling on the unit with a lap belt applied. The seat belt was loose enough that it was able to be pulled away from the resident's abdomen approximately 6-7 inches. This inspector asked the resident to remove the seatbelt and the resident was physically and cognitively unable to do so.

Inspector interviewed RPN #100 who confirmed that resident #041 does not have an order for a restraint and was not sure why the seat belt was applied. RPN #100 concluded that the resident must have applied the seat belt him/herself. The residents seat belt was undone and RPN #100 asked the resident to re-do the belt and the resident was not able to follow this direction.

Inspector #541 interviewed PSW #101 who confirmed she provided resident #041 with assistance today. PSW #101 confirmed that she did apply the residents seat belt and further stated that the resident's chart does not indicate he/she is to have a seat belt on and that resident #041 never tries to get up from the chair. This inspector then asked PSW #101 why she applied the seat belt if the resident does not require it and PSW #101 stated because it was on the chair, she applied it.

On a specified date and time this inspector observed resident #041 sitting in a wheelchair by the nursing station with a seat belt applied. The seat belt was very loose and could be pulled away from the resident's abdomen approximately 6-7 inches. Today when asked to undo the belt, resident #041 was able to undo the seat belt. Inspector spoke with RPN #102 who confirmed by looking in resident's chart that the resident does not have an order for a seat belt. RPN #102 also asked resident #042 to undo the belt and resident again was able to. RPN #102 did state that resident would likely not be able to consistently undo the belt and the resdient does not require one. RPN #102 confirmed the belt was loose and removed it.

Policy #APPENDIX-5 titled Restraints - Protocols for was reviewed. Page 5 of 12 indicates the following:
If a resident is being restrained by a physical device under section 31 or 36 of the Act, the home will ensure that:
1. The device is used in accordance with any manufacturer's instructions
2. Staff only apply the physical restraint that has been ordered or approved and in

accordance with any specific instructions of a physician or registered nurse in the extended class.

The manufacturer's instructions for the pelvic support belt (seat belt) by BodyPoint were reviewed and page 2 states:
- When properly adjusted and the belt tightened, it should fit snug so that the user's pelvis is secure.

The licensee failed to comply with their policy APPENDIX-5 titled "Restraints - Protocols for" as resident #041 was observed on August 23 and 24, 2016 with a loosely applied seat belt and on August 23, 2016 the resident was unable to undo the seat belt therefore making the belt a restraint. Resident #041 does not have a physicians order or consent for the application of a seat belt restraint. [s. 29. (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 their policy to minimize restraining of residents is complied with, to be implemented voluntarily.

Issued on this 25th day of August, 2016

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

Original report signed by the inspector.