Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 13, 2021	2021_961243_0007	012900-21, 016781-21	Complaint

Licensee/Titulaire de permis

The Corporation of the City of London
355 Wellington St, 2nd Floor, Suit 248 London ON N6A 3N7

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

Dearness Home for Senior Citizens
710 Southdale Road East London ON N6E 1R8

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

ANGELA FINLAY (705243), CHRISTINA LEGOUFFE (730)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 1, 2, 3, 6, 7, and 8, 2021.

The following Complaint intakes were completed within this inspection:
Log #016781-21, related to resident restraining and responsive behaviours;
Log #012900-21, related to resident care concerns.

Critical Incident inspection #2021_961243_0006 was done concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Directors of Care (ADOCs), the Physiotherapist, the Registered Dietitian, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Social Worker, the Manager of Community Life, and a resident.

The inspectors also made observations, and reviewed health records, policies, investigation notes, and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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	Légende 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. 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 has failed to ensure that a resident was not 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.

A resident was noted to have exhibited some responsive behaviours and was restrained by staff with the use of a physical device.

The resident did not have the use of physical restraints included in their plan of care.

Staff were disciplined by the home related to this incident. The discipline letters sent by the home to the staff members involved stated that the staff had unreasonably restrained the resident, and that the staff had violated the homes restraints policy.

In separate interviews with two RPNs, they stated that the use of the physical device was inappropriate and did not follow the homes policy. An ADOC stated that the use of the physical device was a restraint in this instance and that with any restraint there is a risk of harm.

Sources: Interviews with two RPNs, and an ADOC, review of the residents clinical records, the homes investigation notes and discipline letters. [s. 30. (1) 3.]

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 as described in section 36, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Findings/Faits saillants :

1. The licensee has failed to ensure that an incident of improper care or improper treatment that resulted in a risk of harm to a resident was immediately reported to the Director.

A resident was noted to have exhibited some responsive behaviours and was restrained by staff with the use of a physical device.

In an interview with an ADOC, they stated that management became aware of this incident on the date it occurred, started an investigation right away, and the investigation was completed after interviewing the staff involved. As per the homes investigation notes, the interviews with the staff involved took place two days after the incident.

In separate interviews with two different RPNs, they both stated that the use of the physical device as a restraint in this instance was an inappropriate way to manage a residents behaviours. The ADOC also stated that the home found that the use of the physical device was a restraint, disciplinary actions were taken, and that with any restraint there is a risk of harm.

No critical incident report was submitted by the home to the Director related to this incident.

Sources: Interviews with an ADOC, and two RPNs, and record review for the resident. [s. 24.]

Issued on this 16th day of December, 2021

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

Original report signed by the inspector.