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

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
Jun 9, 2016	2016_229213_0016	010576-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.2) LP
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

MAITLAND MANOR
290 SOUTH STREET GODERICH ON N7A 4G6

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

RHONDA KUKOLY (213), MELANIE NORTHEY (563), NANCY JOHNSON (538)

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): May 16, 17, 18, 19, 20, 24, 25, 26, 27, 2016

The following were completed concurrently within the RQI:
Complaint log #029042-15 related to responsive behaviours
Complaint log #034503-15 related to physiotherapy
Critical Incident log #026210-16 related to responsive behaviours
Critical Incident log #007618-16 related to falls
Critical Incident log #007586-16 related to alleged staff to resident abuse/neglect
Complaint log #008697-16 related to sleep preferences
Complaint log #010174-16 related to housekeeping and assistive devices
Critical Incident log #012962-16 related to alleged staff to resident abuse/neglect
Critical Incident log #014862-16 related to alleged staff to resident abuse/neglect

Complaint log #001639-16 was also inspected while in the home completing the RQI. Findings of non-compliance related to complaint log #001639-16, inspection #2016_229213_0017 related to documentation have been issued in this report.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, the Director of Care, the Dietary Manger, the Environmental Services Manager, the Program Manager, the Office Manager, the Ward Clerk, the Resident Assessment Instrument (RAI) Coordinator, a Physiotherapist, a Physiotherapy Assistant, two Registered Nurses, six Registered Practical Nurses, 18 Personal Support Workers, three Dietary Aides, one Laundry Aide, three Housekeeping Aides, two Activation Aides, six family members and over forty residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's right have his or her personal health information kept confidential was respected and promoted.

Registered Practical Nurse (RPN) #118 shared in an interview on May 24, 2016, that their own practice for disposal of empty strip packs was to throw them in general garbage and add water to the bag throughout the medication pass and shake it to remove personal health information. The RPN shared that the practice for other nurses was to use the blue plastic container filled with water on top of the medication cart to wash away personal health information (PHI) from the strip pack. The RPN agreed this was the best practice to protect residents' PHI.

Observations of the medication cart in North wing were made by Inspector #563 on May 24, 2016. An empty blue plastic container with black residue was noted on top of the medication cart and used as a sharps container. At the end of the medication pass, after RPN #118 had thrown water in the garbage throughout the medication pass, three strip packs were removed from the garbage at the side of the medication cart by Inspector #563 and one of the strip packs for resident #015 had the resident name and medications clearly identified and personal health information (PHI) had not been removed. RPN #118 agreed the PHI was not removed and resident #015’s PHI was not kept confidential.

In an interview with Interim Administrator #101 on May 24, 2016, the Interim Administrator shared it was the home's practice to use the blue plastic bin on top of the medication cart to dissolve personal health information in water from the empty strip packs. On May 27, 2016, the Administrator shared in an interview that all medication packages containing resident identification were to be stripped of personal health information before disposal, according to the home's policy for medication destruction. [s. 3. (1) 11. iv.]

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 every resident's right have his or her personal health information kept confidential is respected and promoted, to be implemented voluntarily.

WN #2: 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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. 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 complaint was lodged to the Ministry of Health and Long Term Care regarding wake times.

A memo to staff from the DOC dated March 23, 2016 indicated it was acceptable to get residents up before 6am.

The current care plan for resident #019 stated, "the resident has been getting up around 0630 hours as requested".
The current care plan for resident #020 stated, "resident gets up at: 0700-0730 hours".
The current care plan for resident #021 stated, "resident prefers to get up around 0630-0715 hours".

Staff interviews were conducted on May 27, 2016, at 0810 hours by Inspector #538 with Personal Support Workers (PSW) #134, PSW #117, PSW #138, and PSW #140. The PSWs shared that three residents under the PSW assignments were up and ready upon their arrival for the day shift starting at 0600 hours including residents #019, #020 and #021.

In a staff interview with the Director of Care (DOC) #102 on May 27, 2016 at 1245 hours, the DOC agreed that the care set out in the plan of care was not provided to the resident as specified in the plan for sleep preferences for resident #019, #020 & #021. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care, and the effectiveness of the plan of care were documented.

The "PSW Documentation in the Daily Care Flow Sheet" did not include documentation related to if a resident had been turned and repositioned as stated in the plan of care or when the tilt was applied to the manual wheelchair as a method of repositioning.

The current care plan in Point Click Care (PCC) for resident #004 stated to reposition every 2-2.5 hours and as needed while lying in bed or while sitting in wheelchair.

Resident #004 was observed on May 26, 2016, sitting in a wheelchair.

In a staff interview with Personal Support Worker (PSW) #133 on May 26, 2016, the PSW said that the daily care flow sheet does not have a space where turning and repositioning (T&R) would be documented and there was no space for documentation of repositioning.

The provision of the care set out in the plan of care, the outcomes of the care, and the effectiveness of the plan of care were not documented related to turning and repositioning. [s. 6. (9)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care, and the effectiveness of the plan of care were documented.

Personal Support Worker (PSW) Daily Care records for a two week period for residents #080, #020, #068 and #069 identified documentation was completed less than 50 per cent of required occasions for bathing, personal hygiene, level of assistance with eating, etc.

Record review of PSW Treatment Administration Records:
Resident #069:
An identified treatment - documented 9 out of 28 occasions in an identified month in 2016.
An identified treatment - documented 4 out of 8 occasions in an identified month in 2015.

Restraint records for May 2016 for residents #030, #059 and #066 indicated restraint monitoring was documented less than 50 per cent of required occasions.

The "Health Records Policy, Daily Care Records" #HEAL-05-06-01A stated, "The Daily Care Record must be completed by the individual care staff that is responsible for the resident prior to the end of the shift. Care staff that provide care to a resident who is not assigned to them, must record the care provided in that specific resident's daily are record. The care staff must initial the Daily Care Record after recording all the required documentation".

The "Physical Restraints" policy #RESI-10-01-01 stated: "Care staff: Ensure the Restraint Record is completed. Monitoring of restraint use must be completed with hourly safety checks and two hourly position changes which requires the release of the restraint and documented on the restraint record".

In a staff interview with Personal Support Worker (PSW) #123 and Registered Practical Nurse (RPN) #125 on May 24, 2016, RPN #125 said that monitoring of restraints in the home were to be documented on a "Restraint Record" kept with the PSW flow sheets in the flow sheet binders. The PSW and RPN confirmed that the Restraint Records were to be completed by both PSW's and registered staff, to document the safety monitoring on all three shifts, they said that the Restraint Records were not completed in full for resident #059.

In a staff interview with Director of Care (DOC) #102 on May 24, 2016, the DOC said that it was the home's expectation that PSW's complete the Restraint Records to document the hourly monitoring, safety and repositioning of residents with restraints and registered

staff were to document that residents still required the restraint and the restraint was appropriate. The DOC stated the registered staff also document this in the Medication Administration Records, but they were expected to sign these sheets as well. The DOC reviewed the restraint records for residents #030, #059 and #066 and agreed that the PSWs and registered staff did not complete the restraint records as per policy and the home's expectation.

In a staff interview with the Interim Administrator #101 on May 27, 2016, the Interim Administrator said that the daily care records, the restraint monitoring sheets and the PSW treatment administration records were not documented consistently as per the home's expectation. [s. 6. (9)]

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 care set out in the plan of care is provided to the resident as specified in the plan; and that the provision of the care set out in the plan of care, the outcomes of the care, and the effectiveness of the plan of care are documented, to be implemented voluntarily.

WN #3: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or

system was in compliance with and was implemented in accordance with applicable requirements under the Act.

A complaint was lodged to the Ministry of Health and Long Term Care regarding wake times.

A memo to staff from the DOC dated March 23, 2016 indicated it was acceptable to get residents up before 6am.

This procedure for the night staff was not in compliance with or implemented in accordance with applicable requirements under s. 6(5) where by every resident should be given the opportunity to participate fully in the development and implementation of the plan of care. According to O.Reg. s.26(3)21. sleep patterns and preferences are to be based on an interdisciplinary assessment of the resident.

On May 27, 2016, the DOC said the memorandum related to the procedure in place for night staff was not in compliance with and was not implemented in accordance with applicable requirements under the Act. [s. 8. (1) (a)]

2. The licensee has failed to ensure that the home's "Missing personal clothing" policy #HL-06-03-12 was complied with.

The home's "Missing personal clothing" policy #HL-06-13-12, last updated September 2015, indicated:
Laundry staff:
1. At the beginning of your shift, check for reports of missing clothing
5. Sign off on the Missing clothing search form and return it to the Support Services Manager
Appendix 1 – Missing clothing Search form – Laundry Department

In an interview with resident #008 with Inspector #538 on May 19, 2016, the resident reported they were missing an item of clothing and they reported the missing item to staff.
In an interview with resident #010 with Inspector #563 on May18, 2016, the resident reported they were missing an item of clothing and they reported the missing item to staff.
In an interview with resident #029 with Inspector #538 on May 18, 2016, the resident

reported they were missing items of clothing and they reported the missing item to staff.

In a staff interview with three Personal Support Workers (PSW) #117, #132, and #133 on May 26, 2016, the three PSWs said that they had never seen or used the Missing clothing search form when a resident had reported missing clothing.

In a staff interview with a Laundry Aide (LA) #111 and the Environmental Services Manager (ESM) on May 26, 2016, they both said that they had never seen or used the Missing clothing search form when a resident had reported missing clothing. The LA and ESM stated that they did not have a record of reported missing clothing in the laundry area and with this, had no way to identify found clothing that had been reported missing. The ESM agreed that the home was not following the "Missing personal clothing" policy as they were not using the "Missing clothing search form".

In a staff interview with the Administrator #101 on May 26, 2016, the Administrator stated that the home had not been using the "Missing clothing search form" and therefore have not complied with the "Missing personal clothing" policy. [s. 8. (1) (b)]

3. The licensee has failed to ensure that any policy instituted or otherwise put in place was complied with.

The "Night Nurse Schedule" stated on "Saturday", "Check med carts for expired medications (restock insulin, eye gtts, etc.)". Record review of the "Job Routine / Hazards Nights Charge Nurse 1900 - 0700 hr" Policy last reviewed April 2016 revealed, "Key responsibilities: review all stock medications for expiry dates monthly (first weekend of the month)".

In a staff interview with Registered Practical Nurse (RPN) #118 on May 20, 2016, the RPN shared that one bottle of Ferrous Sulphate 300 mg was expired with an expiry date of February 2016 and one bottle of Micro-K Extencaps 600 mg was expired with an expiry date of January 2016 as observed by the inspector at that time. On May 20, 2016 at 1250 hours, the Director of Care (DOC) #102 shared that both identified medications had expired and that it was the home's policy that the night charge nurse responsibilities included reviewing all stock medications for expiry dates monthly.

Observations of the medication cart located in the North wing were made on May 24, 2016. One bottle of " Guaifenesin Bronchophan Expectorant" 100mg/5 ml with DIN #

02121999, Lot # 96FD had an expiry date of "2015-10" and RPN #118 said the medication was expired and stored in the bottom drawer of the medication cart.

In a staff interview with the DOC #102 on May 25, 2016 at 0925 hours, the DOC shared that the "Night Nurse Schedule" was incomplete and shared there was no documentation to support that the night nurse completed the outlined task for checking expired medications by signing the schedule. [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 home's "Missing personal clothing" policy #HL-06-03-12, the "Night Nurse Schedule", and "Job Routine / Hazards Nights Charge Nurse 1900 - 0700 hr", are complied with. Also to ensure that all processes, procedures and policies are compliant with the legislation, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Findings/Faits saillants :

1. The licensee has failed to ensure that, as part of the medication management system, that a written policy was developed in the home that provides for the ongoing identification, destruction and disposal of all expired drugs and all drugs with illegible labels. The drug destruction and disposal policy must also provide for the following: that drugs that were to be destroyed and disposed of shall be separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The "Medication Storage: 4-15" Policy stated, "Medications awaiting destruction should be kept in a separate locked area of the medication room and/or medication cart(s)". Record review of the "Surplus Medications for Destruction: 4-13" Policy states, "All discontinued medication cards are secured in a designated locked stock room or other locked area".

The "Ordering, Receiving, Recycling and Destruction" policy #11-07, the "Surplus Medications for Destruction" policy #4-13, and the "Medication Storage" policy #4-15 did not provide for the ongoing identification, destruction and disposal of all expired drugs or all drugs with illegible labels. The policies did not state that drugs that were to be destroyed and disposed of shall be stored separate from drugs that were available for administration to a resident, until the destruction and disposal occurs.

The Interim Administrator #101 shared in an interview on May 27, 2016, that the medication policies provided to Inspector #563 did not provide instruction related to ongoing identification, destruction and disposal of all expired drugs and all drugs with illegible labels, or that drugs for destruction were to be kept separate from those available for resident use.

The licensee has failed to ensure that non-controlled drugs were destroyed by a team acting together that composed of one member of the registered nursing staff and one other staff member appointed by the Director of Nursing and Personal Care. The licensee also failed to ensure that a) the drug destruction and disposal system was audited at least annually to verify that the home’s procedures are being followed and are effective, b) that any changes identified in the audit are implemented; and c) that a written record is kept of everything provided for in clauses (a) and (b). As well as, the home has failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

Observations of the medication cart were made on May 27, 2016. Inspector #563 observed an open faced clear plastic container in the medication cart between resident medication bins. The clear container had multiple medications in varying shapes, colours, and sizes; and medications were not denatured in any way.

Registered Practical Nurse (RPN) #141 shared on May 27, 2016, that for destruction of non-controlled drugs, registered staff were putting medications in an open faced clear plastic container in the medication cart and when the container was getting full, one registered staff would dump the medications into another locked container in the medication room. The RPN said that the non-controlled medications for destruction sit in the medication cart for several days before placing them in the locked sharps container and explained the medications were not denatured in any way. The RPN also said that

the medications for destruction were stored in the medication cart with medications for resident use.

Observations of the non-controlled drug disposal container were made on May 27, 2016. Inspector #563 observed medications were dropped into the "Sharpsmart Pharmaceutical Waste" container located in the medication room in North wing. The container was locked and the drop lid prevented access to the medications once in the container. Upon shaking the container, the medications were loose and not denatured and this process did not include a team working together as required.

The “Medical Pharmacies - Quality Assurance Summary Report- 2016-02-18” with reference # 67748 stated, “No finding, well done” as part of the “medications for Disposal” for North and South Wing. The “Maitland Manor Quality Protocol for Medication”, dated May 1, 2016, documented that the “home’s management ensures: a) the drug destruction and disposal system is audited at least annually to verify that the home’s procedures are being followed and are effective, b) that any changes identified in the audit are implemented; and c) that a written record is kept of everything provided for in clauses (a) and (b)”. There was no audit documented or completed in 2015 or 2016 and this was verified by the Interim Administrator on May 27, 2016.

On May 27, 2016, the Director of Care #102 said the drug destruction and disposal system was not audited at least annually to verify that the licensee’s procedures are being followed and are effective. [s. 136.]

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, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of all expired drugs and all drugs with illegible labels. The drug destruction and disposal policy must also provide for the following: that drugs that are to be destroyed and disposed of shall be separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

Also, to ensure that non-controlled drugs are destroyed by a team acting together that composed of one member of the registered nursing staff and one other staff member appointed by the Director of Nursing and Personal Care.

To also ensure that a) the drug destruction and disposal system is audited at least annually to verify that the home's procedures are being followed and are effective, b) that any changes identified in the audit are implemented; and c) that a written record is kept of everything provided for in clauses (a) and (b).

As well as, to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Inspector #538 observed Dietary Aide #103 breaking up crackers with their bare hands into a resident's soup bowl, the dietary aide then proceeded to touch another resident on the back, then broke up more crackers and was observed serving the resident their soup, without washing their hands. Dietary Aide #103 said that they had not washed their hands and that it is an expectation that staff wash their hands or use the hand sanitizers available between resident contact and contact with food.

Registered Practical Nurse (RPN) #118 did not perform hand hygiene at any time during an observed medication administration pass to multiple residents in a 45 minute time frame and coughed into their left hand several times without hand hygiene. RPN #118 acknowledged in an interview with Inspector #563 on May 20, 2016, that they did not perform routine hand hygiene between residents and tasks. [s. 229. (4)]

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 staff participate in the infection prevention and control program by completing hand washing when appropriate, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls.

A Morse Fall Scale completed in Point Click Care on an identified date for resident #065 indicated the resident was high risk for falls.

Post falls assessments were completed in Point Click Care in Assessments and in Risk Management on two occasions in 2016 for resident #065.

There were no goals, objectives or interventions related to risk of falls or falls prevention found in the current plan of care for resident #065.

The home's Falls Prevention and Management Program #RESI-10-02-01 included: "Interdisciplinary Team: Review the resident's falls risk assessment in order to establish an individualized care plan and communicate the care plan to all staff. Interventions must address the risk factors identified through the assessment process".

In an interview with the Director of Care (DOC) #102, the DOC said that the home's expectation was that the plan of care was to be updated to include interventions related to falls prevention for residents who were assessed as a high risk for falls. The DOC agreed that resident #065 was assessed as a high risk for falls and that the plan of care for resident #065 did not include interventions related falls prevention as per the expectation. [s. 26. (3) 10.]

WN #7: 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. (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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
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).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device was included in a resident's plan of care only if all of the following were satisfied: 1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk. 3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable methods that would be effective to address the risk.

Inspector #213 observed resident #059 with a potential restraint in place on May 18, 2016. Inspector #213 observed Personal Support Worker (PSW) #123 apply a potential restraint to resident #059 on May 24, 2016.

In an interview with PSW #123, the PSW said that resident #059 was at risk for falls and injury and a restraint was used to prevent falls.

The current plan of care for resident #059 included an identified restraint as a falls prevention intervention. No documentation of assessment related to the use of the identified restraint, the risk, alternatives and method of restraint was found completed in Point Click Care or in the paper chart for resident #059.

The home's policy "Physical Restraints" #RESI-10-01-01 included, "Registered Staff: 1. Assess, 2. Consideration of alternatives, 3. Consultation with the interdisciplinary team".

On May 24, 2016, the DOC said that the home's expectation was that restraint assessments were to be completed in the assessments section in Point Click Care. The DOC agreed that she could not find any assessments related to the use of a restraint for resident #059 as per the expectation. [s. 31. (2)]

Issued on this 10th day of June, 2016

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

Original report signed by the inspector.