Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2012_104196_0029
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Sep 12, 14, 17, 19, 2012
Licensee / Titulaire de permis :	MANITOUWADGE GENERAL HOSPITAL 1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0
LTC Home / Foyer de SLD :	MANITOUWADGE GENERAL HOSPITAL 1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~JUDITH C. HARRIS~~ error & Mr. Jocelyn Bourgoin

To MANITOUWADGE GENERAL HOSPITAL, you are hereby required to comply with the following order(s) by the date (s) set out below:

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that will ensure that the licensee's written policy to minimize the restraining of residents is complied with.

This plan shall be submitted in writing to Inspector Lauren Tenhunen, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch at 159 Cedar Street, Suite 603, Sudbury ON P3E 6A5 or by fax at 1-705-564-3133 by October 2, 2012.

Grounds / Motifs :

1. The licensee's policy and procedure #B-265 titled "Restraints" with a revision date of June 20, 2010 was reviewed by the inspector. The policy referred directly to the Act and to the regulations and included specifically "Every licensee shall ensure that no physical device is applied to restrain a resident who is in bed, except to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary" and under the category of "Prohibited devices that limit movement" it notes that any devices with locks that can only be released by a separate device, such as a key or magnet are not to be used.

Inspector observed on September 12, 2012 at 1520hrs, resident #001 lying in bed with a waist restraint in place. The restraint was secured to the underside of the bed, overlapped the resident's waist with velcro and a had a snap lock. In addition, this resident's wheelchair was observed to have a "pin" lock seat belt in place that requires a separate device to unlock.

The licensee had a policy and procedure for restraints that included information on prohibited devices and the use of restraints in bed, but had not complied with their own policy.

The licensee, failed to ensure that the 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, is complied with. [LTCHA 2007,S.O.2007, c. 8, s. 29 (1).] (196)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2012

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (6) Every licensee shall ensure that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except
(a) to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary; or
(b) if the physical device is a bed rail used in accordance with section 15. O. Reg. 79/10, s. 110 (6).

Order / Ordre :

The licensee shall immediately ensure that no physical devices are applied under section 31 of the Act to restrain a resident who is in bed, except as provided for in the regulations.

The licensee shall prepare, submit and implement a plan for achieving compliance with r. 110(6). The compliance plan shall include how the licensee will ensure that the home will not restrain a resident who is in bed.

This plan must be submitted in writing to Inspector Lauren Tenhunen, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, Ontario, P3E 6A5 or by fax at 1-705-564-3133 on or before October 2, 2012.

Grounds / Motifs :

1. Inspector observed on September 12, 2012 at 1520hrs, resident #001 lying in bed with a waist restraint in place. This restraint was secured to the underside of the bed, overlapped the resident's waist with velcro and it had a snap lock.

Inspector reviewed the RQI licensee inspection report #2011_050151_0004 that was issued to the home on January 5, 2012. A Written Notification with a Voluntary Plan of Correction was issued under O.Reg.79/10,s.110 (6) regarding the use of a restraint in bed for this same resident #001.

The licensee failed to ensure that no physical devices are applied to restrain a resident who is in bed.

The licensee failed to ensure that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except (a) to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary; or (b) if the physical device is a bed rail used in accordance with section 15. [O.Reg.79/10,s.110(6)] (196)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 19, 2012

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 112. 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.

Order / Ordre :

The licensee is required to:
(a) immediately refrain from using any device with locks that can only be released by a separate device, such as a key or magnet, for the resident listed below and all other residents that this applies to and,
(b) prepare, submit and implement a plan for achieving compliance with O.Reg.79/10,s.112., for the resident listed below and all other residents that this applies to.

This plan must be submitted in writing to Inspector Lauren Tenhunen, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, at 159 Cedar Street, Suite 603, Sudbury, Ontario, P3E 6A5 or by fax at 1-705-564-3133 on or before October 2, 2012.

Grounds / Motifs :

1. Resident #001 was observed to have a "pin" lock seat belt on their wheelchair that requires a separate device to release the lock.

The licensee failed to ensure that devices with locks that can only be released by a separate device, such as a key or magnet, are not used in the home. [O.Reg.79/10,s.112] (196)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 19, 2012

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by
Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

The written request for review must be served personally, by registere:! mail, or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

The written request for review must be served personally, by registered mail or by fax upon:
Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1

Fax: (416) 327-7603

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of September, 2012

Signature of Inspector / Signature de l'inspecteur : Lauren Tenhunen #196

Name of Inspector / Nom de l'inspecteur : Lauren Tenhunen

Service Area Office / Bureau régional de services : Sudbury Service Area Office

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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 12, 14, 17, 19, 2012	2012_104196_0029	Follow up

Licensee/Titulaire de permis

MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0

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

MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT, MANITOUWADGE, ON, P0T-2C0

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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Residents

During the course of the inspection, the inspector(s) conducted a tour of the resident home area, observed the provision of care and services to residents, reviewed the health care records of various residents, reviewed the licensee's policies and procedures relating to restraint use.

Ministry of Health and Long-Term Care Log#S-000838-12.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee's policy and procedure #B-265 titled "Restraints" with a revision date of June 20, 2010 was reviewed by the inspector. The policy referred directly to the Act and to the regulations and included specifically "Every licensee shall ensure that no physical device is applied to restrain a resident who is in bed, except to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary" and under the category of "Prohibited devices that limit movement" it notes that any devices with locks that can only be released by a separate device, such as a key or magnet are not to be used.
Inspector observed on September 12, 2012 at 1520hrs, resident #001 lying in their bed with a waist restraint in place. The restraint was secured to the underside of the bed, overlapped the resident's waist with velcro and a had a snap lock. In addition, this resident's wheelchair was observed to have a "pin" lock seat belt in place that requires a separate device to unlock.
The licensee had a policy and procedure for restraints that included information on prohibited devices and the use of restraints in bed, but had not complied with their own policy.

The licensee, failed to ensure that the 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, is complied with. [LTCHA 2007,S.O.2007, c. 8, s. 29 (1).]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (6) Every licensee shall ensure that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except
(a) to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary; or
(b) if the physical device is a bed rail used in accordance with section 15. O. Reg. 79/10, s. 110 (6).

Findings/Faits saillants :

1. Inspector observed on September 12, 2012 at 1520hrs, resident #001 lying in their bed with a waist restraint in place. This restraint was secured to the underside of the bed, overlapped the resident's waist with velcro and it had a snap lock. Inspector reviewed the RQI licensee inspection report #2011_050151_0004 that was issued to the home on January 5, 2012. A Written Notification with a Voluntary Plan of Correction was issued under O.Reg.79/10,s.110(6) regarding the use of a restraint in bed for this same resident #001.
The licensee failed to ensure that no physical devices are applied to restrain a resident who is in bed.

The licensee failed to ensure that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except (a) to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary; or (b) if the physical device is a bed rail used in accordance with section 15. [O.Reg.79/10,s.110(6)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. Resident #001 was observed to have a "pin" lock seat belt on their wheelchair that requires a separate device to release the lock.

The licensee failed to ensure that devices with locks that can only be released by a separate device, such as a key or magnet, are not used in the home. [O.Reg.79/10,s.112]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The care plan for resident #001 was reviewed by the inspector on September 12, 2012. Under the focus of "Physical Restraints" it included the goal of "No falls will occur" and the intervention of "Safety belt at all times in chair to ensure no falls". The kardex includes the treatment of "Pinel Restraint PRN". The doctor's order sheet includes the order of "Pinel restraint prn". An interview was conducted with staff member #103 on September 12, 2012 and it was identified that the "pinel" type restraints are not used in the home and it is just recorded on the orders as this. The kardex, the care plan and the doctor's order sheet have conflicting information as to which type of physical restraint is to be used on this resident and therefore does not give clear direction to staff that may be providing care to this resident.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [LTCHA 2007,S.O.2007,c.8,s.6.(1)(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 that ensures that the written plan of care for this resident and all residents, sets out clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. Resident #001 was observed on September 12, 2012 to have a waist restraint in place while in bed and to also have a "pin" lock seat belt on their wheelchair. Interview was conducted with three direct care staff members, #100, #101 and #102 on September 12, 2012 and these staff all reported that they were not aware that restraints were not to be used for residents while in bed. In addition, staff member #101 denied receiving training in the use of restraints for long term care residents and reported that they were unsure if residents in long term care could even have a restraint applied. Staff member #102 told the inspector that their training consisted of another staff member showing them how to use and apply the restraints and the reason the waist restraint was being used for this particular resident was for safety to prevent falls and because they were confused. It was determined through interviews and by observations of a resident with a prohibited type of seat belt restraint and the use of a restraint in bed, the staff members of the home had not received training in minimizing the restraining of residents and if required, how to do so according to the Act and the regulations.

The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. [LTCHA 2007,S.O.2007,c.8,s.76(7)4.]

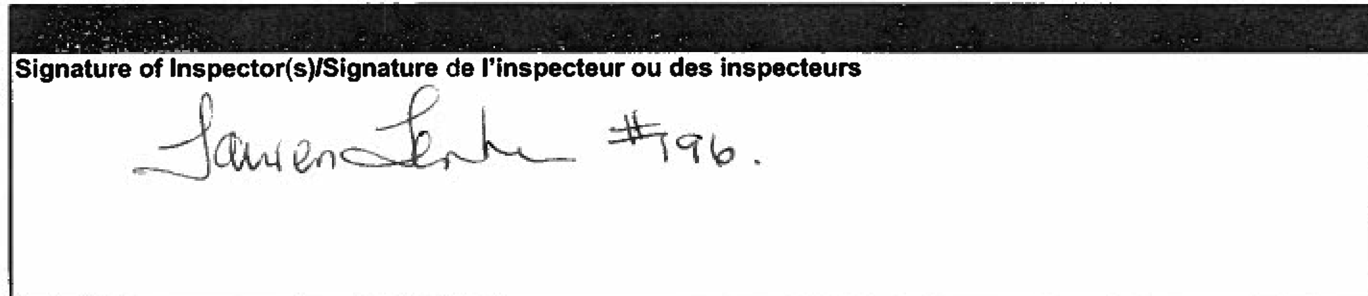
Additional Required Actions:

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 that ensures that all staff who provide direct care to residents receive training in how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 r. 9.	CO #001	2012_138151_0016	196

Issued on this 19th day of September, 2012



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