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

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
Apr 1, 2014	2014_216144_0010	L-000189-14	Resident Quality Inspection

Licensee/Titulaire de permis

MEADOW PARK (CHATHAM) INC
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

MEADOW PARK NURSING HOME (CHATHAM)
110 Sandy Street, CHATHAM, ON, N7L-4X3

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

CAROLEE MILLINER (144), ALISON FALKINGHAM (518), ELISA AGNELLI (171), ROCHELLE SPICER (516)

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): February 24, 25, 26, 27, 28 and March 5, 2014

During the course of the inspection, the inspector(s) spoke with 40+ Residents, the President of the Family Council, two visitors, the Administrator, Director of Care, Co-Director of Care, Registered Dietitian, Food Services Manager, Environmental Services Manager, Life Enrichment Manager, one Restorative Care Aide, four Registered Nurses, ten Registered Practical Nurses, seven Personal Service Workers, two Housekeeping Aides, one Laundry Aide and one Registered Practical Nursing Student.

During the course of the inspection, the inspector(s) toured all resident home areas, observed dining services, medication rooms, medication administration, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information, minutes to relevant meetings and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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.) 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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that there is a written plan of care for each resident that sets out, the planned care for the resident, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident.

- The clinical record for resident #793 includes a diagnosis without a written plan of care to manage the condition.
- Two staff and one management personnel acknowledged the diagnosis and that a written plan of care has not been developed.

- The clinical record for resident #793 includes a resident assessment protocol related to the resident's risk for impaired skin integrity.
- There is no written plan of care developed to manage the risk factors.
- Two staff confirmed a written plan of care has not been developed. [s. 6. (1)]

2. The licensee did not ensure that the plan of care for one resident sets out clear directions to staff and others who provide care to the resident.

- Resident #798 was readmitted from hospital.
- Readmission medical orders included a directive for the resident's mobility.
- The quarterly assessment identifies the resident requires one person limited assistance.

- Observation of the resident and staff interviews confirm the resident requires assistance of two persons. [s. 6. (1) (c)]

3. The licensee did not ensure the plan of care set out clear directions to staff and others who provide direct care to the resident.

- Resident #822 has an intervention in place for safety purposes.
- The resident was observed using the safety device on two days during the inspection.
- The resident was observed not using the safety intervention on one day during the inspection.
- One staff and one management personnel confirmed that the resident should be using the safety intervention at all times. [s. 6. (1) (c)]

4. The licensee did not ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

- Five staff confirmed resident #745 does not independently propel their wheelchair.
- The written plan of care identifies the resident is able to propel themself throughout the facility.
- One staff confirmed the written plan of care was not correct and the resident was not able to propel themself.
- One staff stated the resident is not repositioned every two hours. A second staff confirmed the resident was repositioned every two hours.
- The written plan of care does not include interventions related to repositioning the resident in their wheelchair.
- A third staff member confirmed the written plan of care does not include directives related to use of a special feature on the resident's wheelchair. [s. 6. (1) (c)]

5. The licensee did not ensure that the resident's plan of care was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

- Review of the multidisciplinary data set (MDA) for Resident #786 revealed the resident was dependent with specific aspects of their care needs.
- Review of the Point of Care (POC) documentation and interviews with staff confirm this level of assistance is required.
- The resident care plan which includes goals and interventions, indicated the resident required limited assistance for the specific areas of care referenced above.

- One management staff confirmed the care plan document had not been reviewed and revised when the resident's care needs changed and that it did not reflect the resident's current care needs.
- The manager also confirmed the care plan document and the kardex derived from it are the documents staff would refer to for resident care needs. [s. 6. (10) (b)]

6. The licensee did not ensure that the resident's plan of care was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

- A review of the MDS coding for resident #802 revealed the resident required extensive assistance with regards to hygiene.
- A review of the POC documentation and interviews with staff confirm this level of assistance.
- The care plan document which included goals and interventions, indicated the resident required supervision for hygiene.
- One management staff confirmed the care plan document had not been reviewed and revised when the resident's care needs changed and that it did not reflect the resident's current care needs.
- The manager also confirmed the care plan document and the kardex derived from it are the documents staff would refer to for resident care needs. [s. 6. (10) (b)]

7. The licensee did not ensure that one resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

- Resident #798 was readmitted from hospital.
- Prior to hospitalization the resident required limited assistance for mobility purposes.
- On readmission and to date, the resident is mobile as tolerated and requires assistance of two persons.
- A nursing assessment was not completed on readmission to identify the change in the resident's health status.
- One staff confirmed the assessment was not completed.
- Two management personnel confirmed the assessment is a requirement of the home's Readmission From Hospital Policy and the Ministry of Health Long Term Care Homes Act, 2007. [s. 6. (10) (b)]

8. The licensee did not ensure the resident plan of care was reviewed and revised when the resident's care needs changed.

- Resident #765 experienced a fall.
- The fall incident notes listed interventions to prevent further falls.
- The resident's plan of care did not include these interventions.
- One management staff confirmed that non-registered staff do not have access to resident incident notes and have been directed to request information from registered personnel. [s. 6. (10) (b)]

9. The licensee did not ensure the resident's plan of care was reviewed and revised when the resident's care needs changed.

- The plan of care in place for resident #815 states the resident requires no assistance for mobility purposes.
- Interviews with the resident and two staff revealed the resident currently uses a wheelchair.
- A third staff confirmed the resident's plan of care should iclude the use of a wheelchair for mobility.
[s. 6. (10) (b)]

10. The licensee did not ensure that the resident's plan of care was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

- An interview with two staff indicated resident #745 is not cooperative with care.
- Two staff work with the resident to complete care.
- A review of the care plan interventions for this resident indicated that unco-operativeness and refusal of care should be documented in multi-disciplinary notes (MDN) and , if care is refused, staff are to return in 5-10 minutes to inform the resident of flexible options to complete care.
- Registered staff confirmed these interventions were not relevant at this time and the interventions had not been reviewed and revised when the residents care needs changed. [s. 6. (10) (b)]

11. The licensee did not ensure that the resident's plan of care was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

- Interventions for resident #745 related to dining room services identifies the resident requires extensive assistance.
- Interviews with personal support staff and observations during one meal service,

indicated the resident required total assistance.
- The plan of care had not been reviewed and revised when the resident's care needs changed. [s. 6. (10) (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 there is a written plan of care for each resident that sets out the planned care for the resident, the goals the care is intended to achieve, clear directions to staff and others who provide direct care to the resident and to ensure the care set out in the plan is provided as specified in the plan and the plan of care is reviewed and revised when resident care needs change, to be implemented voluntarily.

WN #2: 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 did not ensure that the home policy and procedure related to medications was complied with.

- The home policy related to administration of medications states "the Registrant shall ensure that the medication is properly packaged and labeled".
- One management staff confirmed the home policy expectation was that all insulin pens in use should be clearly labeled with the resident name.
- One staff member further confirmed that two insulin pens for resident #811 were not clearly labeled with the resident name.
- On one date during the inspection, Inspector #522 and one management staff found one unlabeled insulin pen in the medication cart of one resident home area.
- On a second date during the inspection, Inspector #522 and one management staff observed two insulin pens with illegible names in the medication cart of an alternate resident home area. One resident name was documented on tape and affixed to an insulin pen. Another resident's name resident's name was illegible on an insulin pen. Another insulin pen had an illegible pharmacy label and the name of one resident written in red marker across the pharmacy label.
- One management staff confirmed it was unacceptable to write a resident's name on a piece off tape and affix it to an insulin pen. [s. 8. (1)]

2. The Licensee failed to ensure one home policy and procedure was complied with.

- One home policy related to care of resident equipment states "the Registered Nurse, Registered Practical Nurse or Personal Support Worker will ensure that the equipment is positioned properly.
- During the inspection, the equipment for resident #815 was noted to be sitting on the floor.
- One staff verified that the observed equipment should never be left on the floor. [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 policies and procedures related to administration of medications and urinary catheterization are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails are used, the resident is assessed and the bed system evaluated in accordance with evidence based practices or prevailing practices to minimize risk to the resident.

- The plan of care states resident #822 requires the use of bed rails.
- Two management personal confirmed the resident had not been assessed and the bed system not evaluated using evidenced based or prevailing practices. [s. 15. (1) (a)]

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 where bed rails are used, the resident is assessed and the bed system evaluated in accordance with evidence based practices or prevailing practices to minimize risk to the resident., to be implemented voluntarily.

WN #4: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee did not ensure that a registered dietitian who is a member of the staff of the home completes a nutritional assessment for all residents on admission and whenever there is a significant change in resident's health condition.

- Resident #798 was readmitted from hospital.
- A nutritional referral was made to the Registered Dietitian post readmission.
- One staff confirmed the nutritional assessment had not been completed as of a specific date.
- The Registered Dietitian confirmed their weekly scheduled days to the home.
- One management personnel confirmed the home expectation is that residents readmitted will be assessed by the Registered Dietitian post readmission.
- Two management staff confirmed the Registered Dietitian attended the home on three occasions between readmission and the above identified date and that the resident was not assessed by the Registered Dietitian during those visits. [s. 26. (4) (a)]

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 a registered dietitian who is a member of the staff of the home completes a nutritional assessment for all residents on admission and whenever there is a significant change in resident's health condition., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD 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. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure the use of a personal assistance services device had 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.

- The plan of care for resident # 822 lists equipment intervention used for safety.
- Two management personnel confirmed the equipment are used as a personal assistance services device and that there is no documented consent by the resident or substitute decision maker for the use of identified equipmenr for this resident. [s. 33. (4) 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 the use of a personal assistance services device had 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., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee did not ensure that staff use safe transferring and positioning devices when assisting residents.

- During a tour of the home with one management staff, grab bars attached to toilets in two identified resident rooms, were noted to be loose and would not provide sturdy support to residents requiring their use.
- A second management staff confirmed the bars were loose and that they would be replaced. [s. 36.]

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 use safe transferring and positioning devices when assisting residents., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure residents are monitored during meals, including residents eating in locations other than dining areas.

- During the inspection, resident #854 was observed eating a meal in their bed unsupervised.
- The resident's written plan of care includes the requirement for the resident to receive supervision during meals.
- Two staff and two management personnel confirmed the home protocol and expectation is that resident's do not eat unsupervised in their room. [s. 73. (1) 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 residents are monitored during meals, including residents eating in locations other than dining areas, to be implemented voluntarily.

WN #8: 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 did not ensure that staff participated in the implementation of the infection prevention and control program.

- On multiple days of the inspection, there were a number of items observed to be stored improperly in shared resident bathrooms.
- Items included unlabeled toothbrushes, deodorant, continence products on toilet tanks, a used urinal hanging on the garbage can by a resident bed, one urinal on the back of a toilet.
- One management personnel confirmed that resident personal care items should be stored in a caddy in a drawer in the bedroom and not left in the bathrooms and, that continence products should not be stored on the toilet tanks. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee of a long term care home did not ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

- On one day of the inspection, three Inspectors heard an individual yell "help" [redacted].
- Inspector 516, went to see where the calls were coming from [redacted]
- The resident had slid down in their wheel chair. [redacted].
- Inspectors 516 and 144 reported the incident to two management personnel who initiated an immediate investigation.
- Two management and two staff confirmed the available two staff on the unit at the time of the incident, were assisting a second resident in the tub room and did not hear resident #711's calls for help or the call bell system buzzer.
- Two management personnel confirmed the call bell system is not audible in any of the three tub rooms within the home and that wiring was installed in two tub rooms to initiate call bell audibility however, the project was never completed. [s. 17. (1) (e)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the housekeeping program was evaluated and updated annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

- A review of the housekeeping policies and procedures binder revealed there had not been a sign off signature of review since 2010.
- Two management personnel confirmed the polices in the Housekeeping policy binder were the policies currently in place and that they had not been evaluated and updated since 2010. [s. 30. (1) 3.]

WN #11: 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 did not ensure that before including a restraint in one resident's plan of care, that alternatives to restraining were considered and tried where appropriate and, that a physician or registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

- An Occupational Therapist made a recommendation for resident #745 for positioning purposes.
- Five staff confirmed the resident is not capable of getting out of their wheelchair.
- Two staff confirmed alternatives to the use of a restraint were not considered prior to the use of the wheelchair.
- Two staff acknowledged a physician or registered nurse in the extended class or other person provided for in the regulations did not order or approve the resident be restrained. [s. 31. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's written record was kept up to date at all times.

- The treatment administration record for resident #745 specifies that on a specific shift each day, registered staff are to provide a specific treatment.
- The treatment was not documented on the treatment administration record as being provided to the resident on five dates between February and March 2014.
- One management personnel confirmed the treatment was provided to the resident but not documented on the treatment administration record as having been administered. [s. 231. (b)]

Issued on this 14th day of April, 2014

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