Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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119, rue King Quest, 11ième étage
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
October 14, 2010	2010_192_2607_12Oct194320	Complaint: H - 00886

Licensee/Titulaire
Niagara Health System
63 Third Street
Welland, Ontario
L3B 4W6

Long-Term Care Home/Foyer de soins de longue durée
Niagara Health System, Welland Hospital Site, Extended Care Unit
65 Third Street
Welland, Ontario
L3B 4W6

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

Barbara Naykalyk-Hunt # 146, Debora Saville # 192

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspectors spoke with: The Administrator, Director of Care, and the Resident Assessment Indicators (RAI) Coordinator.

During the course of the inspection, the inspectors: reviewed the resident's health care record, the homes investigation notes related to the incident in question, the home's Abuse/Neglect Policy and observed the resident.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse and Neglect;
Minimizing of Restraint.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 CO: CO # 001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with **LTCHA 2007, S.O. 2007, c.8, 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.

Findings:
The care plan for the identified resident specifies that two care providers are required for the provision of bathing. According to the Administrator, the home is unable to provide the assistance of two staff.

Inspector ID #:	# 146, # 192

WN #2: The Licensee has failed to comply with **O. Reg. 79/10, s. 110**

Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:

1. Staff apply the physical device in accordance with any manufacturer's instructions.

Findings:

1. Manufacturer's instructions received from the home, indicate the belt be "kept tightened at adjustment straps during fitting and daily use to ensure correct pad placement."
   October 14, it was observed that a seat belt for an identified resident was not applied according to the manufactures instructions.

Inspector ID #:	# 146, # 192

WN #3: The Licensee has failed to comply with **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:
3. Any device with locks that can only be released by a separate device, such as a key or magnet.

Findings:

1. On October 14, 2010, a resident had a prohibited device that limits movement in place. This device is being used as a restraint and is monitored by staff as a restraint. This was confirmed by the

Administrator.	
Inspector ID #:	# 146, # 192

Additional Required Actions:

CO # 001 was served on the licensee on October 14, 2010 and was to be complied with immediately.

Signature of Licensee of Designated Representative **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report: October 20, 2010**

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

Name of Inspector:	Barbara Naykalyk-Hunt	**Inspector ID #**	# 146
Inspection Report #:	2010_192_9607_12Oct194320		
Type of Inspection:	Other		
Licensee:	Niagara Health System		
LTC Home:	Niagara Health System, Welland Hospital Site, Extended Care Unit		
Name of Administrator:	Ms. Helen Ferley		

To Niagara Health System, you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg. 79/10, s. 112. 3.
For the purpose of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not uses in the home:
3. Any device with locks that can only be released by a separate device, such as a key or magnet.

Order:

The licensee shall cease and desist from using pen-release restraints on any/all residents within the home.

Grounds:

- Residents were observed to be restrained with a pen-release belt restraint in the long-term care home in October 2010.

This order must be complied with by:	Immediate

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 service for the Licensee.

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
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire 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.

Issued on this 14 October, 2010.	
Signature of Inspector:	Barbara Naykalyk-Hunt
Name of Inspector:	Barbara Naykalyk-Hunt Inspector ID #: 146

Service Area Office:	Hamilton Service Area Office