Ontario

Ministry of Health and Long-Term Care

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

Ministére 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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 23, Feb 3, 22, 2012	2012_026147_0002	Critical Incident

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF ERIN MEADOWS
2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4

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

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Nurse Managers, Registered Staff, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) reviewed resident's clinical records, interviewed staff and residents, reviewed policy and procedure related to Pain Management, Restraint Procedures and Personal Assistance Services Devices and observed resident home areas.

Log #H-000103-12

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Pain

Skin and Wound Care

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. 30. Protection from certain restraining

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The home failed to ensure that no residents of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. The use of bed rails as a restraint is not included in several identified resident's plan of cares:

a. Interview with staff regarding the identified residents confirmed that the staff use two bed rails while residents are in bed for safety, bed mobility or as per request of the residents. The written plan of care for the specified residents identifies that these residents are dependent on staff for repositioning and transferring. It was also confirmed with staff that these residents are unable to unlatch the bed rails independently. In further review of the Plan of Care and The Assessment Protocol summary for the residents, it was noted that none of the above documentation addressed the use of two bedrails as either a restraint or a Personal Assistance Services Device (PASD).

b. There are no physicians orders for identified residents for the use of the two full bed rails as restraint or PASD. The resident's record do not identify that alternative to restraining have been considered. There is no documentation to support Power of Attorney/Substitute Decision Makers (POA/SDM) were involved in the decision to use the two full bed rails.

c. The identified resident's records do not indicate that the residents are being monitored hourly when in bed with the two full bed rails in the up position or that this condition is reassessed and the effectiveness of the restraining is being evaluated at least every eight hours. Staff on the units confirm that they do not monitor the residents hourly when in bed with bed rails up or that the effectiveness is reassessed every eight hours.

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 all residents are protected from being restrained by the use of a physical device, other that in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices;
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device;
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;
(d) types of physical devices permitted to be used;
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented;
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The home's restraint policy does not address the use of bed rails in the up position as a type of physical restraint when used to inhibit the movement of the resident when in bed.

a. Interview with Personal Support Workers (PSW), Registered Staff and Nurse Manager confirmed that staff utilized two side rails up while resident were in bed for safety, bed mobility or as per resident's request. The staff also confirmed that identified residents were incapable of unlatching the bed rail independently. In review of the Plan of Care and The Resident Assessment Protocol summary completed for identified residents; it was noted that none of the above documentation addressed the use of two bedrails as either a restraint or a Personal Assistance Services Device (PASD).

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 the home's written policy under section 29 of the Act deals with types of physical devices permitted to be used, to be implemented voluntarily.

Issued on this 29th day of March, 2012

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