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

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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
Oct 5, 2015	2015_301561_0018	H-003176-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE BRAMPTON
7891 Mclaughlin Road BRAMPTON ON L6Y 5H8

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

DARIA TRZOS (561), JESSICA PALADINO (586), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)

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): September 9, 10, 11, 14, 15, 16, 2015.

The following log numbers were completed during this inspection: H-002526-15.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Practice Leaders for Skin and Wound, Continence Management, Restraints and Medication Management, Social Worker, Programs Coordinator, Environmental Services Manager, Food Service Supervisor, Registered Staff, Resident Council President, Family Council spokesperson, Dietary Aides, Personal Support Workers (PSWs), Housekeeping Aides, Residents and Families.

During the course of the inspection, the inspectors toured the home, observed the provision of care, observed the meal service, reviewed health care records, reviewed relevant policies, procedures and practices, interviewed residents, family members and staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

11 WN(s)
7 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. 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. (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 has failed to ensure that the care set out in resident's plan of care was provided to the resident as specified in the plan.

Resident #019’s documented plan of care indicated the resident’s bed was to be in the lowest position while the resident was in bed as they were at a moderate risk for falls. Observation of the resident while sleeping in bed on an identified date in September 2015, and interview with the registered staff, confirmed the resident’s bed was not in the lowest position. [s. 6. (7)]

2. The licensee failed to ensure that the 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 changed or care set out in the plan had not been effective.

A) Resident #011 had a continence assessment when admitted in 2012, which identified the resident was continent. The resident's three quarterly Minimum Data Set (MDS) assessments in 2015 identified the resident was frequently incontinent. There were no further continence assessments completed using a clinically appropriate assessment tool that was specifically designed for assessing continence. The home’s policy called “Continence Management Program", policy number RESI-10-04-01, and revised November 2013, directed staff to complete a continence assessment using a clinically appropriate assessment tool that was specifically designed for assessing continence with

any deterioration in continence level. The registered staff and the Continence Lead were interviewed and confirmed that a continence assessment using the EO Bladder Continence Assessment tool in Point Click Care (PCC) should have been completed when the resident's continence level deteriorated. The registered staff confirmed that they were expected to complete a continence assessment using a clinically appropriate assessment tool that was specifically designed for assessing continence when the resident's continence deteriorated and this was not completed for resident #011.

B) Resident #014 had a continence assessment when admitted in 2014, which identified the resident was continent and had a catheter. The resident's two quarterly MDS assessments in 2015 identified the resident was frequently incontinent. There were no further continence assessments completed using a clinically appropriate assessment tool that was specifically designed for assessing continence when the resident had their catheter removed and they became incontinent. The home's policy called "Continence Management Program", policy number RESI-10-04-01, and revised November 2013, directed staff to complete a continence assessment using a clinically appropriate assessment tool that was specifically designed for assessing continence with any deterioration in continence level. The registered staff and the Continence Lead were interviewed and confirmed that a continence assessment using the EO Bladder Continence Assessment tool in PCC should have been completed when the resident's continence level deteriorated. The registered staff confirmed that they were expected to complete a continence assessment using a clinically appropriate assessment tool that was specifically designed for assessing continence when the resident's continence deteriorated and this was not completed for resident #014.

C) Resident #019's documented plan of care indicated the resident was at risk for falls. There was no mention of the resident's self-transferring habits after mealtime, or the use of crash mats.

i. In an interview with resident #019's family member, they indicated that the resident had begun to self-transfer more frequently from their wheelchair to their bed after meals, and voiced concerned about the resident's fall risk when self-transferring to bed. Progress notes revealed that the resident had self-transferred themselves from their wheelchair to their bed after meals on multiple occasions. The resident was observed after lunch wheeling themselves from the dining room to their room. Interview with registered staff and PSW confirmed that due to a recent progression in their medical condition, the resident had begun to self-transfer to bed almost daily after every meal.

ii. The resident was observed in bed with crash mats in their room, though these were not in use. Interview with the registered staff confirmed the resident did require the use of the crash mats and that they should have been in use and addressed in the resident’s plan of care.

The resident’s falls risk had not been assessed since March 2015. The resident was not reassessed and their plan of care reviewed and revised when their care needs changed. (586)

D) Resident #018 had a decline in their health status, which prevented them from self-propelling in a wheelchair with a front closing seat belt as a Personal Assistance Services Device (PASD). The resident was observed in a tilted wheelchair, which the home determined based on their assessment to be a restraint. The resident's care needs changed and the care set out in the plan was no longer effective. However, the resident was not reassessed and the plan of care had not been reviewed and revised based on their current needs. The clinical record was reviewed and identified the care needs had changed and no reassessment was completed. The registered staff and PSWs were interviewed and confirmed the plan of care was outdated, the care set out in the plan was no longer effective for the resident, and the plan did not reflect the current needs of the resident. [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 that the care set out in the plan of care is provided to the resident as specified in the plan and to 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 the resident’s care needs change and care set out in the plan has not been effective., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they are not being supervised by staff.

The servery area was left unlocked with the door ajar on the Chinguacousy Home Area at 1135 hours on September 16, 2015. The area was unattended by staff and the LTC Inspector was able to access the servery unnoticed. Staff did not return to the servery until 1142 hours. The steam tables were turned on and hot to the touch and two buckets of cleaning solution were stored uncovered and accessible in the unlocked cupboard under the sink (Ecolab Oasis 137 and 146 - label stated, "Do Not Drink"). The PSW that came to the servery at 1142 hours confirmed the door had been left ajar and was required to be locked to prevent resident access. [s. 9. (1) 2.]

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 doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

Resident #011, #018 and #019 were observed by the LTC Inspector with facial hair over a five day period in September 2015. The residents' confirmed to the LTC Inspector that they would like their facial hair shaved. The PSWs were interviewed and confirmed they were expected to shave residents on a daily basis when needed, and to provide individualized personal care and grooming. The PSWs confirmed that the three residents were unshaven and not well groomed.

Reviewed the home's policy called "Facial Grooming/Cosmetics", policy number RESI-05-07-05, and revised December 2002, which directed staff to remove facial hair for female residents as required to increase their self-esteem and well-groomed appearance.

Reviewed the home's policy called "Shaving the Male Resident", policy number RESI-05-07-06, and revised December 2002, which directed staff to assist to shave or shave on a daily basis unless the resident's choice is to grow a beard. [s. 32.]

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 each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Reviewed the Family Council meeting minutes for year 2015. Not all concerns raised by Family Council were responded to by the licensee within 10 days.

Some examples included:

March 2015 meeting - issues noted with cable tv services, dental services, physiotherapy, and housekeeping. The written response included only cable tv services.

June 1, 2015 meeting - concerns voiced about dental services, staff behaviour, cable tv services, long wait times for call bells, staff not wearing name tags. Written response included staff behaviour and cable tv.

June 29, 2015 meeting - concerns voiced about stacking desserts on top of each other, ice cream should be kept in the freezer, servers do not understand what they are serving, documentation, communication between shifts, staff don't know the residents. The response provided by the home did not include all of the identified concerns.

The Administrator and Social Worker (Family Council Assistant) confirmed that not all concerns or recommendations discussed at the Family Council meetings were responded to by the home. [s. 60. (2)]

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 licensee responds in writing within 10 days of receiving Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping, that procedures were developed and implemented for (b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: (i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs, (ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Resident #036, #039 and #041 were identified as requiring falls mats placed beside their bed as a falls prevention strategy. The falls mats were observed by the LTC Inspector as being significantly soiled on September 10, 11, 14 and 15, 2015.

Two PSWs were interviewed and identified that housekeeping were responsible to clean the falls mats, and then another two PSWs were interviewed and identified that when they see that the falls mats were soiled, they would ask housekeeping to clean them. Two of the housekeeping aides were interviewed and they identified that they depend on the nursing staff to communicate with them if the residents' falls mats needed to be cleaned, and sometimes if they see that the mats were soiled, they would wipe them with a wet floor mop. The Environmental Services policies and procedures were reviewed and the LTC Inspector was unable to locate a policy and procedure, which identified the process for cleaning the falls mats used as a falls prevention strategy for residents.

The Environmental Services Manager (ESM) was interviewed and identified that nursing were expected to communicate with housekeeping if the residents' falls mats needed to be cleaned; however, sometimes the housekeeping aide may observe the falls mat being soiled and would take the initiative to have them cleaned. The ESM confirmed that the process for cleaning soiled resident falls mats was not clear and needed to be formalized. The Administrator also confirmed that the home needed to review the process for cleaning the residents' falls mats and implement a process that was clear to staff. [s. 87. (2) (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 as part of the organized program of housekeeping, that procedures are developed and implemented for (b) cleaning and disinfection of the following in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: (i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs, (ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs complied with manufacturer’s instructions for expiration dates and storage of the drugs.

The LTC Inspector observed expired drugs in the government stock. The expired drugs included:

- Four bottles of Novasen 325 milligrams (mg), which expired in August 2015,
- Three boxes of Nitrostat Sublingual (SL), which expired in November 2014,
- One box of Glycerin Suppositories, which expired in August 2015, and
- Five bottles of Cascara, which expired in December 2013.

The Clinical Practice Leader and DOC were interviewed and confirmed, that the designated registered staff were expected to check the government stock, and remove any expired medications from the home's stock and order replacements, if necessary. [s. 129. (1) (a)]

2. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

The LTC Inspector was in the dining room of the Fletcher's Creek on September 11, 2015 and Summerville units on September 14, 2015 and saw the medication carts unsupervised. When the medication carts were checked the drawers were unlocked. The registered staff confirmed the medication carts were unlocked and unsupervised. The registered staff also confirmed that they were expected to have the medication carts locked at all times when not in use. The DOC was interviewed and confirmed that registered staff were expected to lock the medication carts at all times when not in use. (527) [s. 129. (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 drugs comply with manufacturer's instructions for expiration dates and storage of the drugs and to ensure that drugs are stored in an area or a medication cart that is secured and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On an identified date in September 2015 at lunch time, medication was found in a medication cup on resident #038's table in a resident's room. The registered staff confirmed that this medication was supposed to be taken by the resident at breakfast time and was not supposed to be left in resident's room. The order on the Medical Administration Record (MAR) indicated that this medication was to be given in the morning. The MAR also indicated that the medication was signed as administered to resident at 0800 hours. The licensee failed to ensure that the drug was administered to the resident in accordance with the physician's order. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: 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:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Physical Restraints policy was complied with.

Resident #018 was restrained in a tilted wheel chair with special seating, which was considered a restraint. The home's policy called "Physical Restraints", policy number RESI-10-01-01 and revised November 2012, directed staff to complete the following:

- Complete a restraint assessment
- Consult with the interdisciplinary team, which may involve a care conference and to include, where possible, the resident and or the POA for their participation in the plan of care
- Obtain a physicians order for the restraint or where applicable a nursing order
- Obtain consent from the resident, where possible, or the POA. Consent may be obtained by the telephone, but should be signed by the party giving consent at the earliest opportunity
- Develop a clearly detailed individualized care plan
- Complete a restraint record for monitoring restraint use, which included hourly safety checks and two hourly position changes
- Document the reason for the restraint and the resident's response to the restraint

Based on the review of the resident's clinical record the staff did not complete the documentation as directed by the home's policy and procedures. The registered staff and PSWs were interviewed and confirmed that they had not complied with the home's policy and procedure and document as they were expected. [s. 29. (1) (b)]

WN #9: 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:
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).

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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of resident by a physical device was included in the resident's plan of care only if all of the following were satisfied: 4. A physician, registered nurse in the extended class or other person provided for in the regulations had ordered or approved the restraining.

Resident #018 was observed in a tilted wheel chair at forty-five degrees over a period of six days during the RQI. The home deemed this to be a restraint. The home's policy and procedure called "Physical Restraints", policy number RESI-10-01-01, and revised November 2012, directed staff to obtain an order for the restraint from the physician or where applicable a Nursing Order. The clinical record was reviewed and there was no physician's order or an order from a registered nurse in the extended class for the restraint. The registered staff were interviewed and confirmed there was no order for the restraint and confirmed that based on their policy, they were expected to obtain an order for the restraint. [s. 31. (2) 4.]

2. The licensee failed to ensure that the restraining of resident by a physical device was included in the resident's plan of care only if all of the following were satisfied: 5. The restraining of the resident had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #018 was observed over a six day period with a restraint. The home's policy and procedure called "Physical Restraints", policy number RESI-10-01-01, and revised November 2012, directed staff to obtain consent from the resident, where possible, or the Power of Attorney (POA). The clinical record was review and there was no documented consent. The progress notes were reviewed, specifically the interdisciplinary annual care conference in May 2015, which included the POA and there was no verbal consent obtained during that conference. The registered staff reviewed the clinical record and they were unable to locate a consent for the restraint. [s. 31. (2) 5.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food was prepared and served using methods that preserved taste, nutritive value, appearance and food quality at the lunch meal September 14, 2015.

Minced cucumbers were observed to be very liquid and were running into the sandwiches on the plate. The pureed bread and pasta were observed to be runny and did not hold their form on the plate, resulting in reduced nutritive value, appearance and food quality. The Cook confirmed the texture of the minced and pureed items was too runny. [s. 72. (3) (a)]

WN #11: 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:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident’s response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of the physical device to restrain resident under section 31 of the Act was documented and to ensure that the following was documented: 6. All assessment, reassessment and monitoring, including the resident’s response.

Resident #018 was restrained since an identified date in 2015. The clinical record was reviewed and there was no assessment, reassessment and monitoring, including the resident's response documented in the clinical record until September 2015. The registered staff, Restraint Leads, and the PSWs were interviewed and confirmed there was no documentation in the resident's clinical record. [s. 110. (7) 6.]

Issued on this 13th day of November, 2015

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

Original report signed by the inspector.