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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
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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
Jul 3, 2015	2015_289550_0012	O-001446-14	Follow up

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE BOURGET
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 11 and 12, 2015

This inspection took place on May 11, 12, June 16, 17, 18, 19, 24, 25, 26, and 29, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Regional Manager, the Director of Nursing, a registered nurse, a personal support worker and three residents. The Inspector also reviewed a compliance plan for Compliance Order #001, three resident's health records, the home's restraint policy titled ''Safety Plan - Resident'' and audits for the months of March and April 2015.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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 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. Pursuant to: O. Reg 79/10, 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
(b) is complied with.

The licensee has failed to ensure that where the Act or 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 requires to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

In accordance with the LTCHA 2007, s.29 and O.Reg 79/10, s.109 the licensee 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. Further to this section 109 of the Regulations describes the content, at minimum, to be included within the policy to minimize restraints.

In accordance with LTCHA 2007, s.30 and s.31, a resident is restrained by a physical device when the resident is not able to physically or cognitively remove the device, the device has been included in the plan of care which includes, but is not limited to, the significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.

This inspection was a follow-up inspection for Compliance Order #001 for LTCHA, 2007, s. 8. (1) that was issued on December 22, 2014 as part of inspection #2014_200148_0044 and had a compliance date of March 2, 2015.

Inspector # 550 reviewed the home's restraint policy titled "Safety Plan – Resident", revised September 2013 and observed the following procedures documented in the policy:

1. A meeting of the multidisciplinary team will be held, which may consist of the physician, resident, SDM, person(s) designated by the resident or SDM, nursing staff, Director of Nursing (''DON''), activation aide, dietary aide, etc. At that meeting, the

resident, SDM and/or person(s) designated by the resident or SDM are to be provided with information and/or documentation of the circumstances necessitating the application of the physical device, the nature of the proposed physical device, the expected benefits, the material risks, the material side effects, alternative actions tried (using Appendix A) and the likely consequences of not using the physical restraint.

6. Prior to apply any restraints, seek to obtain the resident's informed consent (or if the resident is incapable, the informed consent of the resident's SDM) to the use of the physical restraint on the resident. The matters outlined in paragraph 1 must be discussed with the resident or SDM, and he or she should be given an opportunity to ask questions and receive satisfactory answers. Record your consent discussion using Appendix B (Consent to Use of the Restraint). Should the resident or SDM refuse consent for a recommended restraint, such refusal shall be documented using Appendix C (Direction to Act Against Medical Advice).

9. The registered nursing staff must reassess the resident's condition and evaluate the effectiveness of the restraining at least every eight (8) hours, and at any other time when necessary based on the resident's condition and circumstances. A task will be added on the EMAR for q8h registered staffs sign off at the start of the shift, indicating whether the restraint is to be continued. The signature indicates that the restraint is safe to apply on this shift and that the registered staff member has completed an assessment of the resident to determine if it is safe to apply the restraint and/or the restraint is still warranted.

10. Registered nursing staff must ensure that every use of a physical device to restrain a resident is fully documented in the resident's progress notes and must include the following:
(a) The circumstances precipitating the application of the physical device;
(b) What alternatives were considered and why those alternatives were inappropriate;
(c) The person who made the order, what device was ordered, and any instructions relating to the order;
(d) Consent to the use of the restraint by the resident or SDM;
(e) The person who applied the device and the time of application;
(f) All assessments, reassessments and monitoring, including the resident's response;
(g) Every release of the device and all repositioning; and
(h) The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Residents #001, #002 and #003 were observed by Inspector #550 at various times on May 11 and 12, 2015.

Resident #001 was observed sitting in a wheelchair with a front closure lap belt and a tray table attached at the back. Resident #001 was able to remove the seat belt but the resident was not able to remove the tray table because it is attached at the back of the wheelchair. PSW staff #S100 indicated to inspector Resident #001 requires a tray table because he/she is at risk for falls due to loss of balance and he/she is able to undo the lap belt on his/her own. The lap belt remains in place to remind the resident not to slide himself/herself off the seat of the chair. Inspector #550 reviewed Resident #001's health records and was unable to find a completed ''Appendix A'' form as per the ''Resident Safety Plan'' to determine what other alternatives to restraining were explored for this resident. Progress notes by registered staff did not indicate all instances of application of the devices and all required information, as per the home's policy.

Resident #002 was observed sitting in a wheelchair with a front closure lap belt and a tray table as restraints. During an interview, RN staff #S101 indicated to inspector Resident #002 requires a lap belt and tray table for safety because of aggressive behaviour and the resident garbs onto things. Resident #002 was not able to remove the two restraints. Inspector #550 reviewed Resident #002's health records and was unable to find a completed ''Appendix A'' form as per the ''Resident Safety Plan'' to determine what other alternatives to restraining were explored for this resident. Inspector reviewed the electronic medication administration record for Resident #002, whereby registered staffs are to sign off at the start of shift, indicating the restraint has been assessed and whether the restraint is to be continued and observed there was no documentation for Resident #002's lap belt. Progress notes by registered staff did not indicate all instances of application of the device or all required information as per the home's policy. The Safety Plan – Consent Form (Appendix B) revealed that no consent had been obtained prior the application of any of the restraints. The form was dated March 03, 2015; it not signed by the resident's substitute decision maker and it did not identify the lap belt restraint.

Resident #003 was observed sitting in a wheelchair wearing a front closure 4 point, red buckle seat belt (which is a 10 pound release button as per the Administrator). The electronic medication administration record for Resident #003, whereby registered staffs are to sign off at the start of shift, indicating the restraint has been assessed and whether the restraint is to be continued was reviewed by Inspector #550. It was observed that there was no documentation for the 4 point, 10 lbs release button seat belt on the

electronic medication administration record. The progress notes by registered staff did not indicate all instances of application of the device or all required information, as per the home's policy.

The Director of nursing indicated to Inspector #550 the documentation of the person who applied the device and time of application, all assessments, reassessments and monitoring, including the resident's response, every release of the device and repositioning and the removal or discontinuance of the device including the time of removal or discontinuance and the post-retraining care is to be documented by registered staff in the resident's progress notes.

The home is still not following their policy titled Safety Plan – Residents which is their policy to minimize restraints. Alternative approaches to the use of restraints, the use of Appendix A (Safety Plan Interventions) was not completed for Residents #001 and #002. No consent has been obtained prior to the application of restraints for Resident #002. There was no documentation in the electronic medication records by registered staff for the assessment of the restraint and whether the restraint were to be continued for Resident #002 and #003.

The licensee has failed to notice that the results of the audits were not compliant with their policy, the Regulations and the established requirements of the Act. [s. 8. (1)]

Additional Required Actions:

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

Issued on this 9th day of July, 2015

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

Original report signed by the inspector.

Ontario

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) :	JOANNE HENRIE (550)
Inspection No. / No de l'inspection :	2015_289550_0012
Log No. / Registre no:	O-001446-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 3, 2015
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE BOURGET 2279 Laval Street, P.O. Box 99, Bourget, ON, K0A-1E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steve Golden

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_200148_0044, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The Licensee shall prepare and submit a plan to ensure that:

There is a quality monitoring program in place to address the following issues:
-other alternatives to restraining are explored
-there is documentation of the person who applied the device and the time of application, all assessments, reassessments and monitoring and the removal or discontinuance and the post-restraining care
-the resident's condition is reassessed and the effectiveness of the restraining is evaluated at least every eight hours and at any other time when necessary; as identified in your restraint policy, and
-consent is obtained prior the application of any restraining device.

Registered staff receive education on the licensee's restraint policy and have their understanding of this policy evaluated.

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

The plan is to be submitted to Joanne Henrie by July 17, 2015 via fax #613-569-9670.

Grounds / Motifs :

1. Pursuant to: O. Reg 79/10, 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
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staff, Director of Nursing ("DON"), activation aide, dietary aide, etc. At that meeting, the resident, SDM and/or person(s) designated by the resident or SDM are to be provided with information and/or documentation of the circumstances necessitating the application of the physical device, the nature of the proposed physical device, the expected benefits, the material risks, the material side effects, alternative actions tried (using Appendix A) and the likely consequences of not using the physical restraint.

6. Prior to apply any restraints, seek to obtain the resident's informed consent (or if the resident is incapable, the informed consent of the resident's SDM) to the use of the physical restraint on the resident. The matters outlined in paragraph 1 must be discussed with the resident or SDM, and he or she should be given an opportunity to ask questions and receive satisfactory answers. Record your consent discussion using Appendix B (Consent to Use of the Restraint). Should the resident or SDM refuse consent for a recommended restraint, such refusal shall be documented using Appendix C (Direction to Act Against Medical Advice).

9. The registered nursing staff must reassess the resident's condition and evaluate the effectiveness of the restraining at least every eight (8) hours, and at any other time when necessary based on the resident's condition and circumstances. A task will be added on the EMAR for q8h registered staffs sign off at the start of the shift, indicating whether the restraint is to be continued. The signature indicates that the restraint is safe to apply on this shift and that the registered staff member has completed an assessment of the resident to determine if it is safe to apply the restraint and/or the restraint is still warranted.

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(b) What alternatives were considered and why those alternatives were inappropriate;
(c) The person who made the order, what device was ordered, and any instructions relating to the order;
(d) Consent to the use of the restraint by the resident or SDM;
(e) The person who applied the device and the time of application;
(f) All assessments, reassessments and monitoring, including the resident's response;

(g) Every release of the device and all repositioning; and
(h) The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Residents #001, #002 and #003 were observed by Inspector #550 at various times on May 11 and 12, 2015.

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Resident #002 was observed sitting in a wheelchair with a front closure lap belt and a tray table as restraints. During an interview, RN staff #S101 indicated to inspector Resident #002 requires a lap belt and tray table for safety because of aggressive behaviour and the resident garbs onto things. Resident #002 was not able to remove the two restraints. Inspector #550 reviewed Resident #002's health records and was unable to find a completed ''Appendix A'' form as per the ''Resident Safety Plan'' to determine what other alternatives to restraining were explored for this resident. Inspector reviewed the electronic medication administration record for Resident #002, whereby registered staffs are to sign off at the start of shift, indicating the restraint has been assessed and whether the restraint is to be continued and observed there was no documentation for Resident #002's lap belt. Progress notes by registered staff did not indicate all instances of application of the device or all required information as per the home's policy. The Safety Plan – Consent Form (Appendix B) revealed that no consent had been obtained prior the application of any of the restraints. The form was dated March 03, 2015; it not signed by the resident's substitute decision maker and it did not identify the lap belt restraint.

Resident #003 was observed sitting in a wheelchair wearing a front closure 4

point, red buckle seat belt (which is a 10 pound release button as per the Administrator). The electronic medication administration record for Resident #003, whereby registered staffs are to sign off at the start of shift, indicating the restraint has been assessed and whether the restraint is to be continued was reviewed by Inspector #550. It was observed that there was no documentation for the 4 point, 10 lbs release button seat belt on the electronic medication administration record. The progress notes by registered staff did not indicate all instances of application of the device or all required information, as per the home's policy.

The Director of nursing indicated to Inspector #550 the documentation of the person who applied the device and time of application, all assessments, reassessments and monitoring, including the resident's response, every release of the device and repositioning and the removal or discontinuance of the device including the time of removal or discontinuance and the post-retraining care is to be documented by registered staff in the resident's progress notes.

The home is still not following their policy titled Safety Plan – Residents which is their policy to minimize restraints. Alternative approaches to the use of restraints, the use of Appendix A (Safety Plan Interventions) was not completed for Residents #001 and #002. No consent has been obtained prior to the application of restraints for Resident #002. There was no documentation in the electronic medication records by registered staff for the assessment of the restraint and whether the restraint were to be continued for Resident #002 and #003.

The licensee has failed to notice that the results of the audits were not compliant with their policy, the Regulations and the established requirements of the Act. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2015

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 fax upon:

Director
c/o Appeals Coordinator
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
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 3rd day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Henrie

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