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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2016	2016_200148_0010	011429-16	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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): April 20, 2016

This follow up inspection was related to the home's minimizing of restraining program. A Compliance Order #001 was issued on December 22, 2014, upon follow up in July 2015 the CO #001 was re-issued.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

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)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2015_289550_0012	148

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of the care are integrated and are consistent with and complement each other, as it relates to the use of physical devices as personal assistance services devices (PASD).

Resident #001 was observed on April 20, 2016 to be seated in a custom wheelchair with a velcro belt applied at the lap and a second applied at the chest. The Inspector confirmed that the resident was unable to physically remove the devices.

The Inspector spoke with RPN #101 and PSW #103, who are both familiar with the resident's condition and care needs. Both staff indicated that the resident is dependent for care including positioning. Neither staff identified the use of the belts to be related to a risk of harm. PSW #103 indicated that the resident also has a table top. This is a device requested by the family and it is rarely applied by staff as the velcro belts provide the positioning assistance needed. She further noted that the private sitter for this resident will apply the table top for use of activities and crafts.

The most recent Minimum Data Set (MDS) Assessment, Section P, coded for the use of a trunk restraint, less than daily.

The most recent physician orders indicated the following:
- Apply table top on all the time when ever resident in wheelchair as PASD for resident's comfort (as requested by POA) reassess every 8 hours
- Quarterly Medication Review, table top apply at all times when resident in wheelchair as PASD and Chest and lap belt when in chair (pelvis and torso straps in use as positioning aids in wheelchair)

The most recent Safety Plan – Consent Form related to the use of the belts, indicated that the name and description of the physical restraint includes, a chest restraint and lap belt when the resident is in the chair.

The most recent Safety Plan – Consent Form, as it relates to the table top only, indicates: table top on when ever resident in wheelchair as PASD for comfort (as requested by POA).

The plan of care for resident #001, under the focus of PASD, indicates the use of all velco straps on wheelchair, to be used properly for positioning/safety. It is also written to apply the table top as needed when in wheelchair or as resident/staff/family requests for activities as a PASD and as positioning aid for arms.

The plan of care under the focus of Fall Risk, indicates to use seat belt / velco pelvis/chest straps and table top PRN when in w/c as PASD per signed consents.

The implementation and use of physical devices for resident #001, including table top and chest and lap belt are not consistent and do not complement each other, as exampled by the most recent MDS assessment, physician orders, staff interviews, consents and plan of care.

Resident #002 was observed on April 20, 2016, to be seated in a wheelchair with a seat belt applied. Upon observation of the resident's room, a table top was noted to be leaning against the wall.

The Inspector spoke with RPN #101, who indicated that the seat belt is used to help position the resident in the chair as the resident tends to lean forward. She noted that the table top was used for puzzles and activities as it relates to behaviour modification. The Inspector spoke with PSW #103, who indicated that the seat belt is used to position the resident. She noted the resident is dependent on staff for repositioning. PSW #103 indicated that the resident does have behaviours that are escalating and the resident will kick out his/her legs and arms and she feels that the belt assists with maintaining the resident in the chair and from sliding out of the chair and hurting himself. When asked about the table top, PSW #103 indicated that the table top is primarily used by the family for activities, however, it has also been used to assist the resident with meals when appropriate.

The most recent physician orders indicate the following:
- Quarterly Medication Review January 1-March 31, 2016, indicates the seat belt and table top for safety/prevent falls as a restraint.
- Quarterly Medication Review April 1-June 30, 2016, indicates the seat belt and table top for safety/prevent falls as a restraint. On April 20, 2016, the order for the seat belt and table top for safety had been modified with pen markings by which "and" and "restraint" were crossed out and replaced with "or and "PASD", respectively.

Two consents exist on the health care record for the physical devices, both with the same date, and documented on the Consent for Use of Restraints form, indicating the substitute decision maker consented to the seat belt or table top, buckle up at the back of the chair, as required for agitation/safety and the second consent indicating seat belt or table top restraint if needed for behaviour, safety and to prevent falls.

Progress note dated in early 2016, as written by the Occupational Therapist, indicates the belt is to maintain position and the padded lap tray is recommended to be placed on the chair to support positioning, both devices considered to be used as a PASD for positioning when seated in the wheelchair.

The plan of care for resident #002, under the focus of PASD is to assist with bed mobility, which indicates that the PASD will be used for safety and fall prevention and to assist with ADLs over the next quarter. It further describes that the resident uses the seat belt for PASD when the table top is not in use. Under the focus of High Risk for Falls, it is indicated to use the seat belt as a positioning aid when in wheelchair for fall prevention if table top not used as PASD.

The implementation and use of physical devices for resident #002, including seat belt and table top are not consistent and do not complement each other, as example by staff interviews, physician orders, consents and plan of care.

Resident #003 was observed on April 20, 2016, to be seated in a wheelchair with a seat belt applied.

The Inspector spoke with the RPN #101 and RN #102, who both indicated the seat belt is used to assist the resident with positioning, both indicated the resident could slide in the chair but that the risk of harm was minimal.

Two consents exist on the health care record for the physical devices, one dated in late December 2014 and the other without a date or signature from the resident or substitute decision maker. Both are documented on the Consent for Use of Restraints form, the 2014 form indicates seat belt in wheelchair for safety as restraint. The second form, under name and description of physical restraint, indicates wheelchair with seat belt.

The plan of care for resident #003 under High Risk for Falls, indicates the use of a seat belt daily as PASD for safety/positioning.

The implementation and use of a physical device for resident #003, including a seat belt are not consistent and do not complement each other, as exampled by staff interviews, consents and plan of care.

Inspector spoke with the home's DOC and Administrator regarding the issue of consistency in the implementation and use of the devices. The DOC was able to demonstrate that all three residents identified are discussed at the monthly safety meetings due to their use of physical devices. After extensive discussion regarding the use of physical devices for the intent of assisting a resident with an ADL versus the intent to reduce the risk of harm, the DOC stated that in the case of resident #001, #002 and #003, the devices are used as a PASD for the activity of daily living, positioning, and the use of the devices are not to prevent risk of harm or safety. [s. 6. (4) (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 plan of care, as it relates to the use of PASDs for resident's #001, #002 and #003, is developed and implemented so that different aspects of the care are integrated, consistent and complement each other, to be implemented voluntarily.

Issued on this 25th day of April, 2016

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

Original report signed by the inspector.