



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

**Rapport d'inspection
prévus 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

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Bureau régional de services d'Ottawa
347, rue Preston, 4^{iem} étage
Ottawa ON K1S 3J4

**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

Telephone: 613-569-5602
Facsimile: 613-569-9670

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

Licensee Copy/Copie du Titulaire Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection February 3, 2011	Inspection No/d'inspection 2011-117-1160-03Feb115454	Type of Inspection/Genre d'inspection Complaint Log # O-000096
Licensee/Titulaire Caessant Care Nursing and Retirement Homes Limited 264 Norwich Avenue Woodstock, ON N4S 3V9 Fax: 519-539-9601		
Long-Term Care Home/Foyer de soins de longue durée Caessant Care Bourget 2279 Laval Street PO. Box 99 Bourget, ON K0J 1E0		
Name of Inspector(s)/Nom de l'inspecteur(s) Lyne Duchesne #117		
Inspection Summary/Sommaire d'inspection		



The purpose of this inspection was to conduct a complaint inspection regarding nursing care and services for a resident.

During the course of the inspection, the inspector spoke with the home's the Director of Care, to a Registered Practical Nurse, to the home's activity director, to two Personal Support Workers and to the resident.

During the course of the inspection, the inspector reviewed the resident's health care record, observed a resident care unit and a resident room.

The following Inspection Protocols were used during this inspection:

- Medication
- Contenance Care and Bowel Management
- Minimizing Restraints
- Personal Support Services

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

1 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

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

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'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the Long-Term Care Homes Program Manual Standards and Criteria.

Criterion A1.14 A physical restraint may be applied to a resident on the direction of registered nurse where there is an immediate risk of injury to him / herself or others. The rationale for the use of the restraint shall be documented. A physician's verbal order shall be obtained within 12-hours of the restraint application and documented, and the resident's care plan shall be revised.

Findings:

- A resident who suffers from dementia, is identified as being an active wanderer in the home. He / she ambulates independently with no use of mobility aids. His / her plan of care indicates



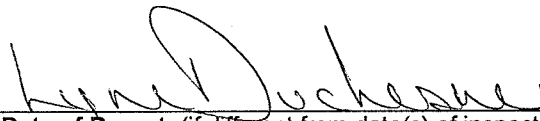
that he /she requires cueing for most of his /her activities of daily living and can occasionally be resistive to care. There are no orders for restraints.

- On June 10 2010, the resident hit the unit Registered Practical Nurse in the face during the evening shift. He /she was actively wandering into other residents rooms while they were sleeping as well as being physically and verbally aggressive to staff. Chart documentation indicates that the resident was restrained for 1 hour when other behavioural interventions were not effective. The restraint was ordered by a Registered Practical Nurse. The attending physician was not notified of the use of the restraint. Nursing staff did not obtain orders for the use of restraint within 12 hours of the restraint application. The resident's plan of care was not revised after the use of a restraint.
- During the evening shift of June 14 2010, the resident was resistive to care, verbally aggressive, yelling and refusing to come out of another resident's room while they were sleeping. Chart documentation indicates that the resident was restrained for an undetermined period of time. The restraint was ordered by a Registered Practical Nurse. The attending physician was not notified of the use of the restraint. Nursing staff did not obtain orders for the use of restraint within the next 12 hours of the restraint application. The resident's plan of care was not revised after the use of a restraint.
- Since these two events, there is no further history of physical restraints being used on the resident.

Inspector ID #: 117

Signature of Licensee or Representative of Licensee
 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: (if different from date(s) of inspection).

February 14, 2011