Ontario

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

Rapport d'inspection prévue 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

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
February 3, 2011	2011-117-1160-03Feb115454	Complaint Log # O-000096

Licensee/Titulaire
Caressant 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
Caressant 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
- Continence 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