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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 15, 2017	2017_618211_0013	006830-17, 009789-17	Critical Incident System

Licensee/Titulaire de permis

UNITED COUNTIES OF PRESCOTT AND RUSSELL
59 Court Street Box 304 L'Orignal ON K0B 1K0

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

RESIDENCE PRESCOTT et RUSSELL
1020, Cartier Boulevard HAWKESBURY ON K6A 1W7

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

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 23, 24, 25, 2017.

During the inspection the following logs were inspected:
Log #009789-17 related to a fall and an incident that occurred causing an injury for which the resident was taken to the hospital.
Log #006830-17 related to falls and an incident that occurred causing an injury for which the resident was taken to the hospital.

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

In addition, the inspector reviewed the staffing schedules, reviewed residents' health care records, relevant licensee policies and procedures, observed resident rooms, the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

This inspection is related to Log # 006830-17. The Critical Incident Report on an identified date was submitted to the Director five days later, indicating that resident #002 sustained an injury after two falls on an identified date.

Resident #002 was admitted to the home on an identified date and diagnosed with multiple medical health conditions. An identified form on a later date, indicated that the resident was diagnosed with cognitive impairment.

The resident health care progress notes reviewed by inspector #211 indicated that resident #002 had multiple falls within a period of approximately four months.

Review of the resident's written plan of care on an identified date, indicated that the resident was identified for high risk for fall. The interventions were to ensure the following:
-The resident has a walker in the room
-The call bell to be available at all times.
-Encourage resident to ask for assistance during transfer and mobility
-The resident has a wheelchair for long distance.

On an identified date during the day shift, the nursing progress notes indicated that the resident had two falls. The nursing progress notes indicated that both times the resident was found lying on the floor on the side of his/her bed. Staff interview said that the chair alarm was applied after the second fall and this was added to the resident's written plan of care. The nursing progress notes indicated that the physician was contacted and a specified test was ordered and an identified analgesic was increased. On the same day, during the evening shift, the nursing progress notes indicated that the resident was found sitting on the floor on his/her buttock in front of the resident's wheelchair. The resident had pushed the chair alarm out from under him/her to the back of the wheelchair which led to the alarm not ringing when he/she slid to the floor.

The next day, the nursing progress notes indicated that the resident did not complain of pain.

Two days after the falls, the nursing progress notes indicated that the resident

complained of severe pain to an identified area. The notes indicated that the physician was contacted and the resident was transferred to the hospital on that day. On the same day, the resident returned to the home during the evening shift. The intervention from the hospital's discharge summary indicated to follow a specified intervention due to the injury.

Inspector #211 reviewed resident #002's discharge summary form from the Hospital on an identified date and indicated that the resident sustained a specified injury.

During an interview with RPN #103 on August 24 2017, indicated to inspector #211 that the resident had already previous pain to the specified body area prior the fall on the identified date. The resident developed an identified health issue and due his/her cognitive impairment, he/she was forgetting to use the walker in his/her room. RPN #103 indicated that a bed and a chair alarm were installed to prevent falls. The resident had another fall at approximately three months later. RPN #103 indicated that the staff heard the alarm but by the time the staff arrived in the resident's room, the resident had already had a fall.

During an interview with RN #102 on August 24 and 25, 2017, she indicated that the resident started complaining of increase pain to the specified body area after the fall on the identified date. RN #102 indicated that a specified test was not done since the technician may take over 24 hours to come to the home. RN #102 indicated that several interventions were tried to decrease the resident pain but since the interventions were not effective, the resident was sent to the hospital two day after the identified falls. RN #102 indicated that the resident returned to the home on the same day during the evening shift. RN #102 stated that the hospital's discharge summary form indicated that the resident sustained a specified injury and the form was given to the home on that evening. RN #102 acknowledged that the resident's fall on the identified date, had caused an injury to the resident that resulted in a significant change in his/her health condition. RN #102 indicated that she thought the legislation indicated she had three calendar days to report the incident to the Director. RN #102 stated that she did not report the incident within one business day.

During an interview with RN #102 and the DOC on August 25, 2017, they understood that the reporting time frame for this kind of incident was within one or three business days. The DOC acknowledged that the home was informed on an identified date that the resident sustained an injury and the Director was not inform within one business day.

The licensee has failed to ensure that the Director was informed of the incident that caused an injury to resident #002 for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition within one business day. [s. 107. (3) 4.]

Issued on this 15th day of September, 2017

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

Original report signed by the inspector.