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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## Public Copy/Copie du public

| 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_0012 | 001697-17 | Complaint |

### 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 Complaint inspection.**

**This inspection was conducted on the following date(s): August 22, 23, 24, 25, 2017**

**The complaint inspection Log #001697-17 was conducted related to resident's discharge and care.**

**During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Director of Care (DOC), and several Personal Support Workers (PSW).**

**In addition, the inspector reviewed the home's staffing schedules and reviewed residents' health care records.**

**The following Inspection Protocols were used during this inspection:**
**Admission and Discharge**
**Continence Care and Bowel Management**
**Medication**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 148. Requirements on licensee before discharging a resident**

**Specifically failed to comply with the following:**

**s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,**
**(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).**
**(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).**
**(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).**
**(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that, before a resident is discharged under subsection 145 (1), the licensee shall:
(a) Ensure that alternatives to discharge have been considered and, where appropriate, tried;
(b) In collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) Ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and
(d) Provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

This inspection is related to Log #001697-17 regarding an unexplained discharge for resident #001.

Resident #001 was admitted to the home on an identified date and diagnosed with cognitives impairment and other medical health conditions. The resident's health care record indicated resident #001 was transferred to an identified hospital several days after he/she was admitted to the home, for responsive behaviours and returned to the home several days later.

A review of the resident's written plan of care for several months before the resident was discharged from the home, indicated that the resident had responsive behaviours and the resident was resistive to care. The interventions for resident's responsive behaviours were regularly updated when the care interventions were no longer effective during the time the resident was living in the home.

A review of the resident's health care record by inspector #211 indicated that resident #001 had frequent episodes of responsive behaviours toward the staff during his/her stay in the home. The resident was followed regularly by the psychogeriatric services and the home's Behavioural Supports Ontario (BSO) team.

On an identified date, resident #001's progress notes written by the Director of Nursing (DOC) indicated that the resident was sent to the hospital after being seen by the psychogeriatric team related to the resident's unpredictable responsive behaviours during an identified week-end. The resident returned to the home several days later.

On another identified date during the evening shift, the nursing progress notes indicated that the resident had responsive behaviours toward the staff while providing care. The notes indicated that the resident safety was in danger. The resident was transferred to the hospital during that evening.

The next day, the nursing progress notes indicated that the resident returned to the home. The nursing progress notes indicated that the resident had responsive behaviours toward the staff. Two different identified medications were given within an identified time frame without effect as resident still exhibited responsive behaviours.

The following day, the nursing progress notes during the night shift indicated that when the staff tried to change the resident's brief, the resident exhibited the responsive behaviours. During the morning shift, the nursing progress notes indicated that the resident demonstrated the responsive behaviours toward the staff even when using the recommended intervention and approach. On two specified times during the afternoon

shift, the nursing progress notes indicated that the resident had other episodes of responsive behaviours toward the staff. The notes indicated that the attending physician and the DOC were informed. During the evening shift, the resident was seen by the attending physician and transferred to an identified hospital.

The next day during the evening shift, the nursing progress notes written by the DOC, indicated that the resident's SDM was informed that resident #001's re-admission to the home would be refused due to his/her unpredictable responsive behaviours.

Two days later, the nursing progress notes written by the DOC indicated that a finalized Ministry of Health and Long-Term Care (MOHLTC) report was completed indicating that the resident was discharged from the home.

Several days later, the nursing progress notes written by the DOC, indicated that she received a letter from resident #001's SDM, asking for the details related to the resident's discharge. The resident's SDM was contacted and a meeting was scheduled for the following week to discuss the reason for discharge.

Inspector #211 reviewed the discharge letter addressed to the SDM on the day after the resident was transferred to the hospital and signed by the Administrator. The letter indicated that the resident was transferred to the hospital on the identified day and the home's multidisciplinary team, along with the physician, made the decision to discharge resident #001 from the Residence and recommend that the resident be sent to a specialized facility for behavioural management. The letter to the SDM indicated that the home doesn't have the ability nor the expertise to cope with such responsive behaviour.

Inspector #211 reviewed the resident's SDM's letter sent to the Administrator, several days after the resident's discharged from the home. The letter indicated: "No notice was given of the identified resident's discharge. Not only was I not informed, I was not consulted to work as part of the team with CCAC to find a more suitable residence for the identified resident."

During an interview on August 22, 2017, the DOC indicated that she tried to have a team conference with the attending physician and the resident's SDM on an identified month, but the conference did not occur since the resident was transferred to the hospital on the identified date. The DOC indicated that the resident was transferred several times to the hospital since the resident's admission for his/her responsive behaviours. The DOC stated that the resident was followed and assessed by the psychogeriatric team and the

home’s BSO team during his/her stay in the home. The DOC indicated that the resident continued to have responsive behaviours toward the staff even with the interventions recommended by the psychogeriatric team. The DOC indicated that the resident had multiple incidents of the same responsive behaviours toward the staff during his/her stay in the home. The DOC stated that a meeting with the multidisciplinary team and the resident’s SDM had occurred on two identified days. The DOC indicated that the discharge letter was sent to the SDM one day after the resident was transferred to the hospital. The DOC indicated that she contacted the CCAC during the week prior the resident's discharged to discuss what other alternative for placement for resident #001 and she was told that the resident’s chart was closed with the CCAC.

The DOC acknowledged that the home discharged the resident on the identified date without the collaboration with the appropriate placement co-ordinator and other service organizations to make alternative arrangements for the accommodation, care and secure environment required for the resident. The DOC indicated that the resident’s SDM was not given an opportunity to participate in the resident’s discharge planning taking in consideration his/her wishes on the day of the resident's discharge from the home. [s. 148. (2)]

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**Issued on this 18th day of September, 2017**

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

**Original report signed by the inspector.**