Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 26, 2021	2021_583117_0007	000525-21, 001069-21	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

LYNE DUCHESNE (117)

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): February 25, 26, March 1, 2, 3, 4, 5, March 8, 9, 10, 15, 16, 17, 18, 19, 22 and 23, 2021

During the course of this inspection, the following inspection Logs were completed
- Log # 000525-21: a complaint related to resident fall and injury
- Log # 001069-21 : a critical incident report CIS # M567-000001-21 related to a resident injury that has resulted in a significant change of condition and for which the resident is taken to hospital and results in a significant change of condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Nursing Coordinator, Registered Nurse (RN), several Registered Practical Nurses (RPNs), several Personnal Support Workers (PSWs), an Attending Physician, a Physiotherapist as well to several residents.

During the course of the inspection, the inspector reviewed several resident health care records, reviewed critical incident report #M567-000001-21, reviewed medication administration records, post fall assessments, Policy #345.02 “Programme de prévention des chutes et diminution des blessures associées », Policy #345.01 “Programme de gestion de la douleur”, Policy #345.03 "Programme des soins de la peau et des plaies" and reviewed infection control practices.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Pain

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Légende 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident is reassessed, and the plan of care reviewed and revised when the resident's care needs change.

Resident #001 sustained a fall with injury on a specified day in 2020. The resident was assessed by RPN #111 and progress notes document the resident's health status at that time.

On the 3rd day post fall, changes were noted to the resident's injury. Progress notes document that there was no assessment or notes relating to the resident's injury for two consecutive days and that the cause of the injury was unknown. RPN #103 assessed the injury and notified the attending physician. No further assessments of the resident's injury were noted for the next two days.

On the 6th day post fall, the resident's injury was assessed and pain at movement noted by RPN #103 and RN #105. The attending physician was notified, and an x-ray of the injury was ordered. No assessment of the resident's injury or health status, or information regarding x-ray request status were noted for the next two days. On the 9th day post fall, RPN #106 assessed the resident, increased pain was reported, the physician notified, and a new medication was prescribed and started.

The following day, there were no assessments of the resident's injury, effectiveness of the new medication nor of the resident's health status.

The next day afterwards, there were no assessments of the injury and effectiveness of the new medication other than pain at mobilization.

On the 12th day post fall, there were no assessments of the injury and effectiveness of

the new medication other than pain at mobilization. After communication with the resident substituted decision maker (SDM), the physician was contacted, and a regularly prescribed pain medication dosage was increased. The effectiveness of the increased medication dosage was not assessed.

During the following two days (day 13 and 14 post fall), RPN #104 assessed the resident's injury and health status. On the 14th day post fall, the physician was notified, assessed changes in the resident's health status and the SDM was notified. The resident was transferred to hospital and diagnosed with a specific injury.

RPNs #103, #104, #106 and RN #105 report that the resident's injury did present with some changes in condition and was intermittently painful at mobilization. They all report that the resident's injury and pain should have been assessed daily as well as the effectiveness of the newly prescribed medications. The DOC reported that when there are changes in a resident's condition and care needs, these should be regularly reassessed, documented and the resident's care needs reviewed and revised. As such, there was actual risk of harm to the resident as the resident's injury and changes in medication were not regularly assessed over a period of 14 days until their transfer to hospital.

Sources: Resident health care record, staff interviews RPNs #103, #104, #106 , #111 and RN #105, DOC, attending physician, Policy #345.02 "Programme de prévention des chutes et diminution des blessures associées », Policy #345.01 "Programme de gestion de la douleur" [s. 6. (10) (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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #001 sustained a fall with injury on a specified day in 2020. The resident was assessed by RPN #111 and progress notes documented the resident's health status at that time. No post-fall assessment was found to be have been completed.

As per the licensee's policy #345.02 "Programme de prévention des chutes et diminution des blessures associées », a post-fall assessment form is to be completed for each resident fall. The RPN #111 indicated that they did not complete the post-fall assessment following the resident's fall. The home's Nursing Coordinator and Director of Care confirmed that a post-fall assessment form should have been completed. By not completing the post-fall assessment form, the nursing staff did not identify, assess and review fall risk issues and interventions in place at the time of the resident's fall.

Sources: Staff interviews Nursing Coordinator, Director of Care and RPN #111, Resident Health Care Record, Policy #345.02 "Programme de prévention des chutes et diminution des blessures associées » [s. 49. (2)]

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 when the resident has fallen, has the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, informe the Director of the incident no later than three business days after the occurrence of the incident.

Resident #001 sustained a fall with injury on a specified day in 2020. Fourteen (14) days later, a significant change in the resident's injury was noted and the resident was transferred to hospital and diagnosed that same day with a specific injury. Ten (10) days later, the resident returned to the home to receive comfort measures.

A critical incident report #M567-000001-21 was submitted to the Director on the day of the resident's return to the home and 8 business days after the home had been notified of the resident's injury and significant change in condition. Resident health care record document and attending physician report that the resident's significant change of condition was known by the home and nursing team the same day the resident was transferred to hospital for further assessment. RN #105 reported that they notified the Director of the critical incident on the day of the resident's return and had not done so when they were informed of the resident's significant change of condition, as identified in the legislation.

Sources: Critical Incident Report #M567-000001-21, Resident health care record, Interview with Attending Physician and RN #105. [s. 107. (3.1)]

Issued on this 3rd day of May, 2021

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

Original report signed by the inspector.