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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 7, 2017	2016_289550_0041	020603-16, 025333-16	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

JOANNE HENRIE (550)

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): November 21, 22, 23, 24 and 25, 2016.

This complaint inspection is related to a complaint regarding staffing issues and the allegations of abuse to a resident.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Director of Care (DOC), the Nursing Care Supervisor, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), a Social Worker, a scheduling clerk, several residents and a family member.

In addition, the inspector reviewed the home's staffing plan and staffing schedules for personal support workers and reviewed residents' health care records. The inspector observed resident care and services and staff and resident interaction.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. According to the LTCHA, S.O, 2007, s. 8 (1) (b) the Licensee of a long-term care home shall ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents.

As per O. Reg. 79/10, s. 31. (3) (a), the staffing plan must provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

Related to Log #025333-16.

A complaint was received related to residents not receiving their care because of staffing issues.

On November 25, 2016, Inspector #550 interviewed resident #002 and #004 who are both alert and oriented. They both indicated to the inspector that when PSWs cannot come to work, they are not replaced. As a result of this, they don't receive the proper care they need; they have to wait long periods of time to be toileted and be put to bed and they are not bathed twice per week. The lack of care was confirmed with PSWs

#100, #103, #104 and #107 during interviews as described below. Documentation in the resident's health care records also confirmed that the care was not provided as per finding under LTCHA, s. 6 identified in WN#2 of this report. The Administrator, the DOC and the Nursing Care Supervisor were aware of the staffing issues in the home.

Inspector #550 reviewed the home's staffing schedule for PSWs for the months of July to November 2016. It was observed that in:
-July: there were 87 shifts not covered,
-August there were 112 shifts not covered,
-September: there were 53 shifts not covered,
-October: there were 34 shifts not covered, and,
-November (1 to 21): there were 16 shifts not covered.

All of the above shifts do not include the shifts that were covered by a PSW working 4hrs instead of 8 hrs. It was also noted by the inspector that during that period of time, some PSWs were authorized leave of absences such as vacation days, special leave and training.

During an interview on November 25 and November 29, 2016, PSWs #100, #103, #104 and #107 indicated to the inspector that PSWs are often working short, during the summer, it was almost on a daily basis and is currently an ongoing issue for the week-ends. Because of this, residents are not getting the proper care they need as their workload is increased when there are PSWs missing at work. PSW #100 further indicated she was working alone with the RPN the day shift on July 31st for twenty six residents.

During an interview on November 22, 2016, the Administrator indicated to the inspector that they have ten on-call PSWs plus four students that they are able to call on week-ends, during the summer and on statutory holidays when a PSW cannot come to work. She explained to the inspector that when a PSW starts a new posting, the home has to wait thirty days before they can post this PSW's previous posting as per the home's collective agreement. This often results that they have to schedule the on-call PSWs which leaves them with no one to call when a PSW cannot come to work at the last minute. She indicated she is in discussion with the Union for this matter.

The Director of Care indicated to the inspector that another reason they are often short staffed, is because there has been an increase in vacant PSW full-time positions which in turn caused a lot of shifts to be replaced.

As evidenced above, the licensee did not ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents. [s. 31. (3)]

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 home's staffing plan provides for a staffing mix that is consistent with resident's assessed care and safety needs, to be implemented voluntarily.

WN #2: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Related to Log #020603-16.

A complaint was received regarding issues related to concerns with contacting resident #001's Power of Attorney for Personal Care regarding care decisions. The complainant indicated he/she was the POA for Personal Care for resident #001 and that since a specified date in 2016, the home was no longer informing him/her of issues regarding the care of resident #001 and that they were now contacting the person who had POA for Property regarding the care issues.

A review of the resident's health care records indicated that resident #001 was admitted to the home in 2015 with multiple diagnosis. Upon his/her admission the resident had valid POA documents dated a specific date in 2012, naming one of his/her children as his/her POA for care and property. There was also a new POA document for property signed by the resident on a specific date in 2016, naming another one of his/her children as POA for property. Documentation in the resident's electronic records in Medicare, indicated that a the latter child is the sole contact person and that he/she has POA for care and property. The name and/or telephone number for the POA for Care does not appear in the resident's contact list.

The inspector reviewed the resident's progress notes for a specific six month period in 2016. It was documented that the child who has the POA for property, was informed of the resident's care issues and also assisted to the care conference with the a specific team and the resident's annual care conference. There was no indication that the resident's child who has POA for care was contacted.

During an interview, the DOC indicated to the inspector that a specific child was named POA for property and care in 2016 and that since then, the home no longer informed the resident's other child who was the previous POA for care regarding care related matters. The Inspector reviewed the POA documents for the resident with the DOC and noted that there were no changes made to the POA for care, only to the one for property. The Social Worker, who was also present, indicated that the POA for care was still the resident's specific child as it was never changed by the resident; only the POA for property was changed. The DOC indicated she thought that both POA's had been changed and this is the reason the resident's specified child name was removed from the resident's health care records and that they no longer involved him/her in resident #001's plan of care.

As evidenced above, the resident's specified child who has POA for care was not given an opportunity to participate fully in the development and implementation of resident #001's plan of care. [s. 6. (5)]

2. The licensee has failed to ensure that the following are documented:
1. The provision of the care set out in the plan of care.

Related to Log #025333-16.

A complaint was received related to residents not receiving their care because of staffing issues.

During an interview on November 25, 2016, resident #002 and #004 both indicated to Inspector #550 that because there are often Personal Support Workers (PSWs) missing and not replaced, they do not get their bath two times per week as scheduled and some weeks they don't get a bath at all.

Inspector #550 reviewed the ''flow sheet monitoring forms'' for resident #002, #003, #004 and #005, and noted that there was no documentation for the care provided to these residents on every shift specifically related to bathing. The documentation was observed as follows:

Resident #002:
-September: 1 out of 7 possible baths was not documented
-October: 2 out of 8 possible baths were not documented
-November: 1 out of 6 possible baths was not documented.

Resident #003:
-July: 5 out of 8 possible baths were not documented.
-August: 5 out of 9 possible baths were not documented.
-September: 3 out of 9 possible baths were not documented.
-November: 2 out of 5 possible baths were not documented.

Resident #004:
-July: 1 out of 9 possible baths was not documented.
-August: 5 out of 9 possible baths were not documented.
-September: 5 out of 8 possible baths were not documented.
-October: 5 out of 9 possible baths were not documented.
-November: 2 out of 6 possible baths were not documented.

Resident #005:

-July: 1 out of 4 possible baths were not documented.
-August: 2 out of 5 possible baths were not documented.
-October: 2 out of 4 possible baths were not documented.

During an interview, PSWs #100, #103 and #104 indicated to the inspector that when they work short staffed, they do not document if they have or have not provided resident care.

During an interviewed with RN #101 and RPN #102 on November 25, 2016, they indicated to the inspector that they are short PSWs especially on week-ends. When PSWs cannot give a resident his/her bath on the scheduled day because of being short staffed, they will re-scheduled it for the next day but usually the next day they are also short staffed and the baths are not given.

During an interview on November 25, 2016, the Nursing Care Supervisor indicated to the inspector that PSWs are expected to document the care they provide to residents on the ''flow sheet monitoring forms'' on each shift. She further indicated that when there are PSWs missing on some shifts, other PSWs have to work short staffed as a result, they indicated to her that they don't have time to document the care they provided on the ''flow sheet monitoring forms''.

As evidenced above, the provision of the care to residents set out in the plan of care is not documented. [s. 6. (9) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Related to Log #025333-16.

A complaint was received related to residents not receiving their care because of staffing issues.

During an interview on November 29, 2016, resident #004 indicated to Inspector #550 that when PSWs cannot come to work they are not replaced and as a result of this, he/she does not get his/her bath twice a week.

Inspector #550 reviewed the documentation regarding bathing in the daily flow sheets for a specified period of time in, 2016, and noted that there was no documentation for three specific dates. Inspector interviewed PSW#100 on November 23, 2016 who indicated that she did not give resident #004 his/her bath on two specified dates because she was working short staff and did not have the time. PSW #107 indicated to the inspector on November 29, 2016 that she never gave a bath to resident #004. She did not recall the reason the resident did not receive his/her bath but indicated that if she did not sign the flow sheets for bathing, it's because it was not given.

During an interviewed with RN #101 and RPN #102 on November 25, 2016, they indicated to the inspector that they are short PSWs especially on week-ends. When PSWs cannot give a resident his/her bath on the scheduled day because of being short staffed, they will re-scheduled it for the next day but usually the next day they are also short staffed and the baths are not given.

Resident #004 was not bathed twice per week as evidenced above. [s. 33. (1)]

Issued on this 7th day of February, 2017

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

Original report signed by the inspector.