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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 17, 2021	2020_583117_0016 (A4)	017479-20, 020322-20, 022234-20	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

Amended by LYNE DUCHESNE (117) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

The Licensee requested an extension to the Director's Order related to compliance order CO #004, issued on January 18, 2021. The Director reviewed and approved the extension. The new compliance due date for the compliance order CO #004 is now March 12, 2021.

This public inspection report has been revised to reflect the decisions made by the Director. A copy of the revised report is attached.

A copy of the revised report is attached.

Issued on this 17th day of February, 2021 (A4)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Amended by LYNE DUCHESNE (117) - (A4)

Amended 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): September 24, 25, 28, 29, 30, October 1, 2, 5, 6, 7, 8, 9, 19, 20, 24, 29, November 9, 12 offsite - October 13, 14, 15, 16, 21, 22, 26, 27, 28, 30, November 2, 3, 4, 5, 6, 10, 16, 17, 18, 19, 2020. It is noted that the home was declared to be in a COVID-19 outbreak on October 9, 2020.

During the course of this inspection the following complaint logs were inspected:

- Log #017479-20 - a complaint related to several concerns related to resident care and services including alleged abuse and retaliation, medication administration, physiotherapy services, continence care, essential visitors, care conference, maintenance services and infection control.

- Log #020322-20 - a complaint related to essential visitors and resident pain management

- Log #022234-20 - a complaint related to resident pain management, laundry and housekeeping services and visitations.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Nursing Supervisor, several Registered Nurses (RNs) several Registered Practical Nurses (RPNs) several Personal Support Workers (PSWs), an attending Physician, a Physiotherapist, several Physiotherapy aides, Food Service and Activities Manager, several dietary aides, several activity aides, Scheduling staff, Environmental Services Manager, several housekeeping aides, laundry services staff, maintenance staff, Eastern Ontario Public Health Unit staff members, EMS paramedics, Red Cross staff members and to several residents.

During the course of the inspection, the inspector(s) reviewed the following: several resident health care records, physiotherapy records, medication administration, medication administration records and policy "Administration orale de medicaments" - # 340.09, medication incident reports, registered nursing and PSW staffing schedules, activities and visitor schedules, correspondence to resident families regarding Essential Caregivers, legal correspondence, observed infection control procedures as well as the provision of resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Snack Observation
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.

- **7 WN(s)**
- **4 VPC(s)**
- **3 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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies regarding medication administration are implemented in accordance with prevailing practices.

Residents #001, #004 and #005 have medications that are to be administered by the home's registered nursing staff. As per the home's medication administration policy #340.09, when medication are administered, these are to be documented in the electronic medication administration record (eMAR). A review of resident #001, #004 and #005 electronic Medication Administration Records (eMARs) for the months of July, August and September 2020, show that administered medications were not documented as being administered in the eMARs

For the three residents, a total of five medication, over the course of a three-month period, were not consistently documented as being administered. This occurred 10 times for one identified medication, twice for two identified medication, and once for two other identified medication.

The eMAR documentation and medication administration practices were reviewed with the home's ADOC and DOC. The eMAR medication administration documentation is a two-step signature process. The medications were signed as being prepared and verified, they were administered but were not signed (second step) as being administered in the eMAR. By not completing the documentation process, this poses a potential risk to the residents as registered staff would not be aware that the medication were administered leading either to missed medication doses or the possibility of a second medication administration.

Sources: Resident Health Care Records, Medication Administration Records, Policy "Administration [s. 114. (3) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no Personnel Support Workers (PSW) administered a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

The Care Coordinator stated that a PSW had administered oral medications to residents on a specified date in September 2020, under their supervision. Three PSWs acknowledged giving oral medication to residents that had been prepared by a registered nursing staff. The Nursing Supervisor confirmed that she believed that the PSWs were permitted to administer resident's oral medication while being supervised by a registered nursing staff.

Sources: Staff interview PSWs #111, #116, #119, Care Coordinator, Nursing Supervisor and other staff, Ontario Personal Support Worker Association (opswa). [s. 131. (3)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings of the "Orders of the Director":

The licensee failed to ensure that residents #001, #012 and #013 be provided with physiotherapy services as specified in their plan of care.

Resident #001, #012 and #013 have identified medical conditions.

Resident #001's plan of care identifies that the resident is to have physiotherapy services four (4) times per week. As per documentation and the resident, they did not receive therapy services on (7) times in August 2020, as well as (4) times in September 2020.

Resident #012's plan of care identifies that the resident is to have physiotherapy services five (5) times per week. As per documentation, the resident did not receive therapy (six) times in August.

Resident #013's plan of care identifies that the resident is to have physiotherapy services five (5) times per week. As per documentation and the resident, they did not receive therapy on (5) times in August.

PTA # 110 and #111 stated that residents #001, #012 and #013 had not received physiotherapy services as either one or the other were not available to provide physiotherapy services on specified days in August and in September 2020. No arrangements were made to ensure that the residents receive their therapy when either one or the other PTA are not available. As such, the residents were not provided with physiotherapy services to help maintain their strength and range of motion as per their plans of care.

A COVID-19 outbreak was declared on October 9, 2020, and as a result, the home suspended physiotherapy services from October 9, 2020 to November 12, 2020. Services were to resume on November 13, 2020. In an email from the Administrator, they

stated that physiotherapy services had been suspended on November 18, 2020, as a result of a COVID-19 positive
case in the home.

Resident #001 reported having increased pain since the suspension of the physiotherapy services.

Resident #012 and #013 reported generalized discomfort since the suspension of physiotherapy services. No alternatives to physiotherapy services had been provided to resident #001, #012, and #013 since the start of the COVID-19 outbreak.

The physician stated that they were unaware that the home had suspended physiotherapy services during the COVID-19 outbreak. The physician indicated that "nothing replaces physical treatment to maintain a resident's mobility and range of motion". They further recommended that the physiotherapist share basic physiotherapy exercises with PSW's and registered
staff which could be completed during resident care.

Resident #001 confirmed that the staff do assist with general movement, when asked. Resident #001's progress note showed that resident #001 had requested physiotherapy and exercises. PSW #103 provided exercises for resident #001, and PSW #155 applied lotion. These actions were not documented in the progress notes.

PTA #110 stated that non-physio staff could perform basic physiotherapy exercises on residents. They could do general exercises when repositioning the residents during care. There were no exercise entries in the progress notes.

Resident #001 informed registered nursing staff and EMS staff of their pain. Medication was offered but Resident #001 refused. The resident said they felt that the medication would not be as effective as doing a range of motion exercises. The resident said that they had asked a few specific PSW staff members to do some range of motion exercises, and on a few occasions, asked them to apply a medicated cream.

PSW #103 and #111 confirmed that the resident asked them to do some range of motion exercises and that these were done, when asked by the resident. PSW #155 said that they had applied medicated cream to the resident's limbs,
when requested by the resident. All three PSWs said that they had not regularly informed registered nursing staff that they had provided range of motion exercises to the resident and or that they had applied medicated cream to the resident's limbs.

RPN #104, #176, #182, and RN #164 reported to the inspector and documented in the progress notes that Resident #001 had informed them on a few occasions of having pain and had inquired about accessing physiotherapy services. They said that they had offered pain medication to the resident, which the resident had refused and had informed the resident that therapy services were not available during the outbreak. All said that they had not assessed why the resident was inquiring about accessing therapy services or sufficient alternatives that could be provided.

The home's administrator and ADOC #117 said that they contacted resident #001's family member for several weeks regarding the availability of physiotherapy and range of motion exercises for the resident during the COVID-19 outbreak. These concerns were brought forward by the administrator and ADOC to the unit's registered nursing staff's attention. As per
the administrator and ADOC, the nursing and PSW staff were aware that if the resident expressed a need for exercises, these could be provided depending on staff workload due to the COVID-19 outbreak. The exercises were not provided on a consistent basis as identified in the plan of care.

Resident #012 and #013 also confirmed the suspension of physiotherapy services. Both residents explained that staff would assist with repositioning, when asked. There was no alternate plan for physiotherapy services.

Additional Required Actions:

Refer to the "Orders of the Director"

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents have the right to have any family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home.

In August 2020 a request was made by a resident family member to have a care conference to review the resident's care needs. The home's DOC spoke in person with the resident regarding their wishes for a care conference, which would be held via teleconference as per the home's current pandemic practice for care conferences. The resident verbally agreed to this course of action. A date for the care conference was initially scheduled for a few days later.

The resident's family member communicated with the home's management team that the resident wished to have identified family members present for the care conference. The home's Administrator communicated to the resident and family member, that since the start of the pandemic, all resident care conferences were being done via teleconference or video conference. The resident expressed to the inspectors that they wished to have identified family members physically present at their side during the care conference to facilitate communication with the interdisciplinary care team. The administrator has agreed to family presence via telephone or video conference but not to the physical presence at resident side as per resident's expressed wishes. By not allowing family members to be present, this poses a risk to the resident's rights to have persons of importance to the resident attend meeting and offer in person support.

It is noted that a COVID-19 outbreak was declared on October 9, 2020 and at this time, the care conference has not been held.

Sources: Interviews with resident, Administrator and Director of Care, email correspondence, health care record [s. 3. (1) 27.]

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 every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents

COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, re-issued and implemented on September 9, 2020, states the following:
"Managing Visitors. The aim of managing visitors is to balance the need to mitigate risks to residents, staff and visitors with the mental, physical and spiritual needs of residents for their quality of life. Homes must have a visitor policy in place that is compliant with this Directive and is guided by applicable policies, amended from time to time, from the MLTC and MSAA. "

On September 2, 2020 the Ontario Ministry of Long-Term Care (MLTC) released "Resuming Visits in Long-Term Care Homes". The document identifies caregivers as follows:
" A caregiver is a type of essential visitor who is designated by the resident and/or their substitute decision-maker and is visiting to provide direct care to the resident (e.g., supporting feeding, mobility, personal hygiene, cognitive stimulation, communication, meaningful connection, relational continuity and assistance in decision-making)."

As per the document, LTC homes are responsible for establishing and implementing visiting practices that comply with Directive #3 and align with the guidance in this policy.

On September 17, 2020 the LTC home sent a letter to all residents' family members regarding the new MLTC Visitor Guidelines that were in effect as of September 9, 2020. The letter specified that persons wanting to be designated as essential caregivers, would need to provide all of the following care and services

" . . the following are the criteria that define a care provider as interpreted by the Residence. Must provide direct care while in the Residence including
- hygiene - change of continence products - feeding
- porterring - cognitive stimulation - communication
- meaningful connection".

On a specified day in September 2020, the home's administrator's correspondence to a resident's family members stated that for the Residence, a caregiver must provide all the services identified in the September 17, 2020 letter and that these directives would be applied to all residents. The administrator reiterated to the inspector that any essential caregiver at the Residence would need to provide all identified services.

As per the "Resuming Visits in Long-Term Care Homes" document, essential caregivers can provide any of the listed care interventions. By stating that all identified care and services are to be done by essential caregivers, the LTC home's visitor policy is not in alignment with the MLTC Directive #3 and Visitor policies. The LTC home's policy therefore restricts residents from having caregivers who cannot perform all the identified care and services and poses potential harm to the mental, physical and spiritual needs of residents for their quality of life.

Sources: Interviews with resident, designated essential caregivers, Administrator, EO PHU, Documents including email correspondence, Provincial Directive #3 and Provincial LTC Visitor Guidelines Sept 2, 2020. [s. 5.]

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #7: 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 discharging a resident under subsection 145 (1) the licensee did not
(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.

On a specified day in July 2020, a resident received a letter from the LTC home legal representatives. The letter indicated that the resident was to be discharged on or before a specified date. A review of the letter, the resident's health care record and interview with the resident shows that alternatives to discharge were not considered and, where appropriate, tried, there was no collaboration with the appropriate placement co-ordinator and other health service organization to make alternative arrangements for the accommodation, care and secure environment that may be required by the resident; the resident was not kept informed and given an opportunity to participate in the discharge planning and they did not provide a written notice to the resident 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.

As per the Administrator, it was the licensee's legal representative who wrote the letter of discharge. He acknowledged that the letter did not contain information related to the discharge process, the exploration of alternatives and resident participation in the discharge process, as the resident was already involved with LHIN services. By not providing all the required information, the resident and or their legal substitute decision maker would not be able to have all necessary information to help them understand and participate in the discharge process.

Sources: Interview with resident and administrator, Legal Document, Resident Health care record [s. 148. (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 Before discharging a resident 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., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

A COVID-19 outbreak was declared at the LTC home on October 9, 2020. As per RN #116, infection control measures were immediately put in place regarding the donning and doffing of personal protective equipment (PPE), as per the home's infection control program and directives from the Eastern Ontario Public Health Unit and the Canadian Red Cross.

On a specified day in October 2020, a resident reported an incident where by staff had entered their room without having changed their PPE. PSW #152 and EMS #180 said that they had entered resident's room to provide care to the resident. Upon entry, they identified that they had not changed their PPEs. They exited the room, changed into new PPEs, re-entered the room and provided care to the resident. The resident, PSW and EMS staff all said that no care was provided to the resident until the PPEs had been changed. By not following the infection control signage and changing their PPEs prior to entering the resident's room, staff posed a potential risk of resident exposure to COVID-19.

Sources: Interviews with a resident, PSW #152, EMS #180, RN #116, Observations of Infection Control Signage [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

(A3)
The following Non-Compliance has been Revoked / La non-conformité suivante a été révoquée: WN #1

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).

Issued on this 17 th day of Febraury, 2021 (A4)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LYNE DUCHESNE (117) - (A4)
Inspection No. / No de l'inspection :	2020_583117_0016 (A4)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	017479-20, 020322-20, 022234-20 (A4)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 17, 2021(A4)
Licensee / Titulaire de permis :	United Counties of Prescott and Russell 59 Court Street, Box 304, L'orignal, ON, K0B-1K0
LTC Home / Foyer de SLD :	Residence Prescott et Russell 1020 Cartier Boulevard, Hawkesbury, ON, K6A-1W7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Alexandre Gorman

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To United Counties of Prescott and Russell, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

(A1)(Appeal/Dir# DR# 141)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(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
(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).

Ontario

Ministry of Long-Term Care

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Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 114 (3)

The licensee shall:
1. Ensure that all registered nursing staff of the long-term care (LTC) home are reeducated
on the licensee's policies related to the administration of medication documentation,
2. Conduct weekly audits for four (4) consecutive weeks to assess compliance with the home's written policies and protocols in relation to the administration of medication documentation
3. Document, implement and re-evaluate corrective actions to address any identified deficiencies while ensuring that lessons learned are incorporated into the quality improvement processes.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policies regarding medication administration are implemented in accordance with prevailing practices.

Residents #001, #004 and #005 have medications that are to be administered by the home's registered nursing staff. As per the home's medication administration policy

#340.09, when medication are administered, these are to be documented in the electronic medication administration record (eMAR). A review of resident #001, #004 and #005 electronic Medication Administration Records (eMARs) for the months of July, August and September 2020, show that administered medications were not documented as being administered in the eMARs

For the three residents, a total of five medication, over the course of a three-month period, were not consistently documented as being administered. This occurred 10 times for one identified medication, twice for two identified medication, and once for two other identified medication.

The eMAR documentation and medication administration practices were reviewed with the home's ADOC and DOC. The eMAR medication administration documentation is a two-step signature process. The medications were signed as being prepared and verified, they were administered but were not signed (second step) as being administered in the eMAR. By not completing the documentation process, this poses a potential risk to the residents as registered staff would not be aware that the medication were administered leading either to missed medication doses or the possibility of a second medication administration.

Sources: Resident Health Care Records, Medication Administration Records, Policy "Administration orale de medicaments" - # 340.09, Medication incident reports, staff interviews DOC and ADOC

An order was made by taking the following factors into account:

Severity: Several instances of registered nursing staff not documenting administered medications to three (3) residents, posing potential risk of harm to residents.

Scope: This non-compliance is widespread because as it affects three (3) identified residents.

Compliance History: This section of the regulation under O.Reg. s. 114 (3) has not been issued to the licensee in the past 36 months.
(117)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 131 (3)

The licensee shall:
1. Ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, unless specified under OCMH Directive #3.
2. Document and implement a corrective action plan to address the above identified deficiency.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that no Personnel Support Workers (PSW) administered a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

The Care Coordinator stated that a PSW had administered oral medications to residents on a specified date in September 2020, under their supervision. Three PSWs acknowledged giving oral medication to residents that had been prepared by a registered nursing staff. The Nursing Supervisor confirmed that she believed that the PSWs were permitted to administer resident's oral medication while being supervised by a registered nursing staff.

Sources: Staff interview PSWs #111, #116, #119, Care Coordinator, Nursing Supervisor and other staff, Ontario Personal Support Worker Association (opswa)

An order was made by taking the following factors into account:

Severity: Three identified PSW staff, instead of registered nursing staff, administered medications to residents, posing potential risk of harm to residents.

Scope: This non-compliance is widespread because as it affects the several residents.

Compliance History: This section of the regulation under O.Reg. s. 131 (3) has not been issued to the licensee in the past 36 months.

(211)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2020

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

(A1)(Appeal/Dir# DR# 141)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 17th day of February, 2021 (A4)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by LYNE DUCHESNE (117) - (A4)

Ontario

Ministry of Long-Term Care

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Service Area Office / Bureau régional de services : Ottawa Service Area Office