Ontario

**Ministry of Long-Term Care**

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

**Ministère des Soins de longue durée**

**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 21, 2022 | 2022_831211_0003 | 020260-21 | 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): March 14, 15, 16, 18, 2022 (onsite) and March 21, 22, 23, 24, 28, 31,2022 (offsite).

The following intake log #020260-21 related to a resident's responsive behaviors and an incident that causes an injury for which the resident was taken to the hospital and resulted in a significant change in resident's health status was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurses (RPNs) and a Personal Support Worker (PSW).

In addition, the inspectors reviewed several residents' health care records, and several licensee's policies and procedures: Psychogeriatric Consultation "Consultation en Psychogériatrie", Responsive Behavior Program "Programme de Comportement Réactif ", Responsive Behaviors Assessment in Residents "Évaluation des Comportements Réactifs (Adaptés) chez les residents" and observed the provision of care and services and staff and resident interactions. Furthermore, the inspector observed resident care and services related to Infection Prevention and Control procedures and techniques.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
2 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 | Légende<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 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).**

**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 has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan related to the resident's responsive behaviors monitoring.

A physician ordered to complete an observation sheet to document the resident's responsive behaviors for one week on an identified date.

Review of the resident's progress notes for that week, does not indicate that the observation sheet was implemented or in progress thereof.

The DOC stated that they were unable to find the complete observational sheet related to the monitoring of the resident's responsive behaviors ordered by the primary physician for that week.

As such, the licensee has failed to ensure that the resident's observational sheet to monitor the resident's responsive behaviors was provided as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that a resident who exhibited responsive behaviors was reassessed, and the plan of care reviewed and revised at any other time when the care set out in the plan was not effective to minimize the risk of altercations and potentially harmful interactions between and among residents.

A resident's care plans indicated that the resident was exhibiting one type of aggressive

responsive behavior.

The resident's progress notes documented by the physician for two different dates within three months indicated that the resident's responsive behaviors were improving. Later after the above three months, the physician documented on five different dates within 5 months that the resident was stable and to continue the current treatment.

However, the resident's "Behavioral Supports Ontario (BSO) observation and documentation sheets and the resident's progress notes indicated that the resident was exhibiting one or two different types of aggressive responsive behaviors towards other residents or staff members for a specific item. These incidents occurred on numerous different dates during several months.

The resident's health care records indicated that different interventions were implemented to manage the resident's aggressive responsive behaviors. The plan was to monitor and adjust the medication and to monitor the resident's behaviors via an Observation System sheet as needed. Within several months, the Behavioral Supports Ontario (BSO) staff member were involved to observe, support, and manage the resident's responsive behaviors. However, the resident continued to exhibit many aggressive responsive behavior episodes.

There was no injury involved during the altercation between the identified resident and other residents during several months. However, there was a resident to resident's altercation that led to an injury to the resident thereafter.

A Registered Nursing Staff validated that the resident's care plan did not specifically indicate that the resident was exhibiting several types of aggressive behaviors with other residents or a staff member relating to a specific item.

The DOC stated that a specialized external referral for the resident's responsive behaviors was not carried out. The home did not have a Behavioral Supports Ontario (BSO) staff members to support residents who has responsive behaviors after a certain date. The DOC validated that there was no multidisciplinary conference related to the resident's aggressive responsive behaviors.

There was actual risk of harm to the resident and other residents during several months, as they failed to reassess and reviewed the resident's plan of care related to the resident's aggressive responsive behaviors at any other time when the care set out in the

plan was not effective.

Sources: Review of residents' health care records and interviews with the DOC and staff members. [s. 6. (10) (c)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

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

**s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:**
**1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).**
**2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).**
**3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).**
**4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that protocols for the referral of a resident for specialized resources was developed to meet the needs of residents with responsive behaviors.

A resident's "Behavioral Supports Ontario (BSO) observation and documentation sheets and the resident's progress notes indicated that the resident was exhibiting one or two different types of aggressive responsive behaviors towards other residents or staff members relating to a specific item. These incidents occurred on numerous different dates during several months.

The licensee's Psychogeriatric Consultation "Consultation en Psychogériatrie" policy and procedure indicated when the interventions to help a resident with behavioral problems have not been successful, the nurse or another intervener must complete the consultation request form for a request for psychogeriatrics "Lorsque les interventions pour aider un résident présentant des troubles de comportement n'ont pas bien réussi, l'infirmière ou un autre intervenant doit remplir le formulaire de demande de consultation pour une demande en psychogériatrie».

The DOC stated that the specialized referral for the resident's responsive behaviors was not implemented.

As such, an external specialized referral was not implemented for the resident's aggressive responsive behaviors. Consequently, there was an actual risk of harmful altercations between the resident and other residents. As a result, the resident sustained an injury after an altercation with another resident after several incidents of aggressive responsive behaviors from the resident towards other residents and staff members.

Sources: Review of residents' health care records, licensee's Residence Prescott Russell policy "Psychogeriatric Consultation" and interviews with the DOC and staff members. [s. 53. (1) 4.]

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**Issued on this 25th day of April, 2022**

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

**Original report signed by the inspector.**