Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: April 3, 2024	
Inspection Number: 2024-1577-0001	
Inspection Type: Complaint	
Licensee: United Counties of Prescott and Russell	
Long Term Care Home and City: Residence Prescott et Russell, Hawkesbury	
Lead Inspector Joelle Taillefer (211)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 15, 16, 21-23, 26-29, 2024 and March 4-6, 2024.

The following intake(s) were inspected:
complaints:
·Intakes: #00095845 and #00107521- related Resident Care and Support Services.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
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.

The licensee has failed to ensure that the provision of the care set out in the plan of care related to providing beverage and snack during an identified shift was documented.

Rational and Summary:
Review of the sheets titled "Tableau de Collation" for a date in September 2023, for an identified unit indicated that the staff members did not document for several residents that they received their beverage and their snack during a specific hour.

A staff member stated that beverage and snack were offered to the residents during a specific hour, but they often did not document it on the sheets, as they prioritized providing care to residents.

As the beverage and snack consumed by the residents were not documented by staff members, there was a potential risk that residents were not offered or did not

consume their minimum of beverage and a snack on a date in September 2023, during the identified shift.

Sources: Residents' health care records, and interview with a staff member.
[211]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable.

The licensee has failed to ensure that each resident who required continence care was sufficiently changed to remain clean, dry and comfortable.

Rationale and Summary:
In September 2023, there was correspondence in regard to a lack of staff to the Long-Term Care's management indicating that several residents' continence care was not provided on an identified floor during an identified shift.

The Resident Assessment Instrument (RAI) Coordinator stated that the documentation of the identified residents' flowsheet indicated that toileting was not documented on that date in 2023, during the identified shift.

A staff member stated the toileting for residents who required two-person

assistance was not provided due to a lack of staff on the floor on a specified date in 2023, during an identified shift.

A staff member stated that the scheduling plan indicated to have one PSW to cover each unit on the three floors of the home, one Registered Nursing Staff to cover each floor, and a PSW "floater" for the identified shift.

The Director of Care confirmed that the residents' continence care on a date in September 2023, was not provided during the identified shift because of a lack of staffing.

As such, there was a risk that residents who did not receive continence care product change on a date in September 2023, during the identified shift were not clean, dry and comfortable.

Sources: Several residents' health care records, and interviews with two staff members, Resident Assessment Instrument (RAI) Coordinator, and the DOC.
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WRITTEN NOTIFICATION: Menu planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (b)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

The licensee has failed to ensure that each resident was offered a minimum of a

beverage in the identified time.

Rational and Summary:
Review of the sheets titled “Tableau de Collation” has a legend with different codes that signified: 1= 100 percent (%) ate all, 2= 75%, 3=50%, 4= 25%, 0= resident refused to eat, large glass= 200 milliliter (ml) and small glass=125 ml.

The sheets titled “Tableau de Collation” for an identified date in September 2023, for a specified unit indicated that a staff member documented that multiple residents did not receive their beverage by documenting “0” beside the areas “liquid and water” in the identified shift.

The staff member stated documenting a "0" on the residents’ sheets was not because the residents refused their beverage but because residents did not receive their beverage on the identified date and time in September 2023. The staff member stated that they were unable to distribute the residents’ beverage.

As such, there was a potential health risk for residents when they were not receiving their beverage on a date in September 2023, during the identified time.

Sources: Residents’ health care records, and interview with a staff member.
[211]

WRITTEN NOTIFICATION: Menu planning

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (c)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,

(c) a snack in the afternoon and evening. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that each resident was offered a minimum of a snack during an identified time.

Rational and Summary:
Review of the sheets titled "Tableau de Collation" has a legend with different codes that signified: 1= 100 percent (%) ate all, 2= 75%, 3=50%, 4= 25%, 0= resident refused to eat.

The residents 'sheet titled "Tableau de Collation" for a date in September 2023, for an identified unit indicated that a staff member documented a "0" beside the column "solid".

The staff member stated documenting a "0" on the residents' sheets was not because the residents refused their snack but because residents did not receive their snacks on the date in September 2023, at an identified time. The staff member stated that they were unable to distribute the residents' snack.

The Nursing Care Supervisor stated that residents may not have been provided their snacks on the specified unit on a date in September 2023, during the identified time, as there was insufficient staff during that identified period in 2023.

As such, there was an actual health risk for residents when they were not receiving their snack on a date in September 2023, during the identified time.

Sources: Residents' health care records, interviews with a staff member and the Nursing Care Supervisor.
[211]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a medication incident involving a resident was reported to the resident's substitute decision-maker.

Rational and Summary:
The resident's Medication Administration Record (MAR) for a month in 2023, indicated to administer a medication with a specified amount of milligrams (mg) per each tablet, twice daily.

The Resident's medication incident report titled "Amelioration de la gestion d'administration de medicaments" on a date in 2023, indicated that the resident was administered an incorrect dose of an identified medication for several days. The medication incident report indicated that the resident's substitute decision maker

(resident/responsible) was not informed of the medication incident.

The Director of Care (DOC) confirmed that the resident medication incident was not reported to the resident's substitute decision maker (SDM).

As such, the resident's SDM was not informed of the medication incident that could had potentially been a risk to the resident's health.

Sources: A resident's MAR, and medication incident report titled "Amelioration de la gestion d'administration de medicaments". Interview with the DOC.
[211]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
-Ensure that a designated infection prevention and control (IPAC) lead person works

regularly in that position on site for at least 26.25 hours per week.
-The Director of Care will keep a documented record indicating the hours the designated infection prevention and control (IPAC) lead person worked weekly in that position on site, until this order is complied with the Ministry of Long Term Care.

Grounds
The licensee has failed to ensure that the home has a designated infection prevention and control (IPAC) lead person on site who works regularly in that position for licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

Record review of the “Plan et Programme de Prevention des Infections” revised in October 2022, doesn't identify the Infection Prevention and Control (IPAC) Lead of the home.

The Director of Care (DOC) stated that they were the IPAC lead. The DOC was unable to determine the hours allocated to the role of Infection Prevention and Control (IPAC) lead as they were presently performing both roles.

As such, there was a potential risk for the residents' health and safety as an IPAC lead was not assigned designated hours for IPAC.

Sources: review IPAC “Plan et Programme de Prevention des Infections” and interview with the Director of Care (DOC).
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This order must be complied with by May 10, 2024

COMPLIANCE ORDER CO #002 Administration of drugs

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Ensure that all residents who were prescribed their medications at a specified hour are administered as prescribed by the physician, and as indicated by their home pharmacy service provider.
2. Create a documented backup plan when the home is not fully staffed by registered nursing staff during the identified shift to ensure that residents have received their prescribed medications at the specified hour, as indicated by their home pharmacy service provider. Document and monitor the adherence of the backup plan, as well of any corrective actions taken when residents were not administered their medications at the specified hour as prescribed by the physician.
3. The DOC or the Nursing Care Supervisor perform twice weekly audits by including the dates on five residents who should have received their medication at the specified hour when the home was not fully staffed by registered nursing staff for the identified shift until the order is complied with. The audits shall indicate residents' name, the medication's name, the dosage, the time the medication was prescribed and the date and time the medication was administered. Any discrepancies based on the audit results should be documented by the person responsible for these audits.
4. Provide education to registered nursing staff to ensure that correct dosages of

residents' medication are accurate before the medication are administered. Keep a record with the date of the registered nursing staff who participated in the education.

Grounds

A) The licensee has failed to ensure that drugs were administered to several residents in accordance with the direction for use specified by the prescriber.

Review of a resident's Medication Administration Records (MAR) for three identified months, indicated that the resident was prescribed several medications to be administered at an identified hour. These medications prescribed by the physician at the identified hour were administered over one hour later for several specified dates as confirmed by the Nursing Care Supervisor. A Registered Nursing Staff stated that the resident's medications were prescribed to be administered at an identified hour by the physician and as requested by the resident for a specified health condition.

A second resident's MARs for multiple identified months indicated that the resident was prescribed a medication to be administered at an identified time prior their care. These medications prescribed by the physician at the identified hour were administered over one hour later for several specified dates as confirmed by the Nursing Care Supervisor.

A third resident's MARs for several identified months, indicated that the resident was prescribed several medications to be administered at a specified hour, prior to the resident's care. These medications prescribed by the physician at the specified hour were administered over an hour later for several identified dates as confirmed by the Nursing Care Supervisor. A Registered Nursing Staff indicated that the resident was experiencing severe pain at a specified time during care.

Another resident's MARs for several identified months, indicated that the resident was prescribed a medication to be administered at a specified hour. The medication prescribed by the physician at the specified hour was administered over one hour later, for several identified dates as confirmed by the Nursing Care Supervisor. Review of the correspondence sent by Registered Nursing Staff to a physician on an identified date in 2023, indicated that the resident was experiencing pain during care at a specified time. The physician replied to administer the resident's pain medication at a specified hour.

Another resident's MARs for several identified months, indicated that the resident was prescribed several medications to be administered at a specified hour. These medications prescribed by the physician at the specified hour were administered over one hour later on several identified dates as confirmed by the Nursing Care Supervisor.

Another resident's MAR for a identified date, indicated that several identified medications for a specified hour were administered over an hour later as confirmed by the Nursing Care Supervisor.

Another resident's MAR for an identified date, indicated that several medications prescribed for a specified hour were administered over an hour later as confirmed by the Nursing Care Supervisor.

A Registered Nursing Staff stated that residents' medication prescribed at the identified hour were not administered because they often did not have sufficient Registered Nursing staff during the identified shift.

A Scheduling Technician stated that the scheduling plan was to have a specified amount of Registered Nursing staff on each floors during the identified shift. The

Scheduling Technician identified that the home's scheduling sheets indicated that they were missing Registered Nursing staff.

The Nursing Care Supervisor and the home pharmacist service provider stated that the current standard of practice for medication administration in a Long-Term Care facility is the medication be given within one hour, either before or after, the prescribed administration time in the MAR.

As such, several residents were not administered their medication in accordance with the direction for use specified by the prescriber. Consequently, since these residents' medications were ordered at a specified hour and administered later, there was a potential risk that the resident did not have the optimal effective outcome of care because of the delay in administering the medication.

Sources: Residents' health care records, and interviews with two Registered Nursing Staff and a Scheduling Technician.
[211]

B)The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A resident's quarterly reassessment of the resident's drug regime on an identified date in 2023, indicated to administer an identified medication with a specified amount of milligram (mg) for each tablet, twice daily.

The resident's medication incident report titled "Amelioration de la gestion d'administration de medicaments" on a date in 2023, indicated that the resident was administered an incorrect dosage of an identified medication for several days.

The Director of Care (DOC) stated that the registered nursing staff must ensure that the medication tablets corresponded with the right dosage prescribed by the physician. Consequently, the resident was administered an incorrect medication dosage for several days.

As such, the resident's health condition was placed at risk when their prescribed medication was not administered in accordance with the direction of the prescriber for several days.

Sources: A resident's health care record and interview with the DOC.
[211]

This order must be complied with by May 10, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

O. Reg. 79/10s. 131 (2) 2022-04-21 Written Notification 0000-1577-0000
O. Reg. 246/22s. 140 (2) 2023-06-26 Compliance Order 2023-1577-0001

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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