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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

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Téléphone: (613) 569-5602
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
May 01, 2014;	2014_289550_0010 (A1)	O-000223-14	Critical Incident

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) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

CO #001 from the Public Report copy was not ameneded as no changes were required.

Issued on this 1 day of May 2014 (A1)

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

Ontario

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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) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 25 and April 9, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nursing Care Supervisor, two Registered Practical Nurses and several Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed Critical incident report #M567-000003-14, one resident's health records and reviewed the Home's "Recours minimal à la contention" policy # 330.01.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8 s. 6 (10) (c) in that the resident was not reassessed and his/her plan of care was not reviewed and revised when the care set out in the plan was not effective.

A review of Resident #1's health record indicates he/she was admitted to the Home in the summer of 2013 and upon his/her admission he/she was identified at being at risk for falls due to an unstable gait and balance, cognitive deficit and poor judgment.

A review of the progress notes for a period of 9 months following his/her admission indicated the following:

-on a specific day in August 2013 Resident #1 lost his/her balance and fell over backwards.
-on specific day in November 2013, Resident #1 was found on the floor beside his/her bed in his/her room.
-on a specific day in November 2013, Resident #1 was found on the floor sitting in front of the sink in his/her room.
-on a specific day in December 2013, Resident #1 fell in his/her room during care while a PSW turned to pick up a brief.
-on a specific day in December 2013, Resident #1 was in the lounge and while attempting to sit down in a lazyboy chair he/she missed the chair and fell on the floor.
-on a specific day in December 2013, Resident #1 tripped on the legs of a small table in the dining room and fell on the floor.
-on a specific day in January 2014, Resident #1 was found on the floor beside his/her bed in his/her room.
-on a specific day in February 2014, Resident #1 was found on the floor in his/her room.
-on a specific day in March 2014, Resident #1 was found on the floor in his/her room.
-on a specific day in March 2014, Resident #1 was found on the floor at the end of his/her bed in his/her room.
-on a specific day in March 2014, Resident #1 was in hallway, lost his/her balance and fell on the floor.

Six days following his/her last fall on a specific day in March 2014, Resident #1 died from complications due to injury sustained during his/her fall.

A review of the most recent care plan dated a specific date in January 2014 indicates Resident #1 is at risk of falling, he/she is to be verified regularly to ensure he/she has not fallen and to provide physical assistance if necessary. It also indicates a bed alarm is used at night when he/she is in bed. These goals and interventions are identical to his/her care plan dated a specific date in July 2013 and a specific date in November 2013. There were no indications that the resident was reassessed and the plan of

care revised when the care set out in the plan was not effective as it related to ongoing falls. The progress notes do not indicate other approaches that were considered until after his/her last fall on a specific date in March 2014 when resident was placed in a wheelchair and a lap belt was applied. Staffs #101, 102, 103 and 104 confirmed that no other approaches were considered.

During a discussion the Director of Care confirmed to Inspector #550 the Resident's plan of care was not reviewed and revised after each falls. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 in that the Licensee does not have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

Staffs # 101, 102 and 103 told inspector they are not aware of a fall and management program implemented in the Home.

The Director of Care and the Nursing Care Supervisor indicated to Inspector #550 that an interdisciplinary falls prevention and management program has not been implemented in the Home. They indicated that a program is being developed but was not implemented at the time of the inspection. [s. 48. (1) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, r.49. (2) in that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident # 1 fell on a specific date in August, two specific dates in November, three specific dates in December 2013, a specific date in January, a specific date in February and three specific dates in March 2014. A review of the resident's health records indicates no post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls following each of the falls. Staff #101 told inspector #550 the Home does not have a post-fall assessment tool. This was confirmed by the DOC and the Nursing Care Coordinator. [s. 49. (2)]

Issued on this 1 day of May 2014 (A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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

Health System Accountability and Performance Division
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Name of Inspector (ID #) /
Nom de l’inspecteur (No) : JOANNE HENRIE (550) - (A1)

Inspection No. /
No de l’inspection : 2014_289550_0010 (A1)

Appeal/Dir# /
Appel/Dir#:

Log No. /
Registre no. : O-000223-14 (A1)

Type of Inspection /
Genre d’inspection: Critical Incident

Report Date(s) /
Date(s) du Rapport : May 01, 2014;(A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : LOUISE LALONDE

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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

(A1)
The Licensee will reassess residents who have been identified as high risk for falls and ensure the care set out in the plan of care is effective. The plans of care shall be reviewed and revised if it has been determined that the care set out in the plan has not been effecitve.

Grounds / Motifs :

(A1)
1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8 s. 6 (10) (c) in that the resident was not reassessed and his plan of care was not reviewed and revised when the care set out in the plan was not effective.

A review of Resident #1 s health record indicates he was admitted to the Home on July 15, 2013 and upon his admission he was identified at being at risk for falls due

to an unstable gait and balance, cognitive deficit and poor judgement.

A review of the progress notes from July 2013 to March 2014 indicated the following:

-on August 10, 2013 Resident #1 lost his balance and fell over backwards.
-on November 6, 2013, Resident #1 was found on the floor beside his bed in his room.
-on November 7 Resident #1 was found on the floor sitting in front of the sink in his room.
-on December 8, 2013 Resident #1 fell in his room during care while a PSW turned to pick up a brief.
-on December 10, 2013 Resident #1 was in the lounge and while attempting to sit down in a lazyboy chair he missed the chair and fell on the floor.
-on December 19, 2013 Resident #1 tripped on the legs of a small table in the dining room and fell on the floor.
-on January 10, 2014 Resident #1 was found on the floor beside his bed in his room.
-on February 9, 2014 Resident #1 was found on the floor in his room.
-on March 1st, 2014 Resident #1 was found on the floor in his room.
-on March 9, 2014 Resident #1 was found on the floor at the end of his bed in his room.
-on March 15, 2014 Resident #1 was in hallway, lost his balance and fell on the floor.

Six days following his last fall on March 15, 2014, Resident #1 died from complications of traumatic brain injury sustained during his fall.

A review of the most recent care plan dated January 28, 2014 indicates Resident #1 is at risk of falling, he is to be verified regularly to ensure he has not fallen and to provide physical assistance if necessary. It also indicates a bed alarm is used at night when he is in bed. These goals and interventions are identical to his care plan dated July 15, 2013 and November 03, 2013. There were no indications that the resident was reassessed and the plan of care revised when the care set out in the plan was not effective as it related to ongoing falls. The progress notes do not indicate other approaches that were considered until after his last fall on March 15, 2014 when resident was placed in a wheelchair and a lap belt was applied. Staffs #101, 102, 103 and 104 confirmed that no other approaches were considered.

During a discussion the Director of Care confirmed to Inspector #550 the Resident s

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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.

plan of care was not reviewed and revised after each falls. (550)

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

May 09, 2014

REVIEW/APPEAL INFORMATION

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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.

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

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Order(s) of the Inspector

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Ministère de la Santé et des Soins de longue durée

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.

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 1 day of May 2014 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JOANNE HENRIE

Service Area Office /
Bureau régional de services : Ottawa