Ontario

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

# Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*


**Ministry of Health and Long-Term Care**
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St., 4th Floor
Ottawa ON K1S 3J4

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347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

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Télécopieur: 613-569-9670


☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public

| Date(s) of inspection/Date de l'inspection | Inspection No/ d'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| September 29, 2010 | 2010_188_9567_29Sep103811 | Critial Incident<br>Log # O-000920 |

**Licensee/Titulaire**

United Counties of Prescott and Russell
59 Court Street
Box 304
L'Orignal, ON
K0B 1K0
FAX : 1-613-675-4547

**Long-Term Care Home/Foyer de soins de longue durée**

Résidence Prescott et Russell
1020 Cartier Boulevard
Hawkesbury, ON
K6A 1W7
Fax: (613) 632-4056

**Name of Inspector(s)/Nom de l'inspecteur(s)**

Lyne Duchesne #117

## Inspection Summary/Sommaire d'inspection

Ontario

**Ministry Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

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The purpose of this inspection was to conduct a critical incident inspection related to a resident assaulting another resident.

During the course of the inspection, the inspector spoke with the home's director of care; with the registered nurse and registered practical nurse of one unit, with the registered practical nurse of another unit, to 3 health care aids from several resident care units and to the two residents involved in the reported incident.

During the course of the inspection, the inspector reviewed both residents' health care records, reviewed the 1st floor unit 24-hour nursing report and examined two resident rooms.

The following Inspection Protocol was used during this inspection:

- Responsive Behaviours

Findings of Non-Compliance were found during this inspection. The following action was taken:

**4 WN**
**3 VPC**
**1 CO: CO # 001**

## NON- COMPLIANCE / (Non-respectés)

**Definitions/Définitions**

**WN** – Written Notifications/Avis écrit
**VPC** – Voluntary Plan of Correction/Plan de redressement volontaire
**DR** – Director Referral/Régisseur envoyé
**CO** – Compliance Order/Ordres de conformité
**WAO** – Work and Activity Order/Ordres: travaux et activités

| | |
|---|---|
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.<br><br>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.) | Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.<br><br>Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi. |

**WN #1:** The Licensee has failed to comply with the 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

(9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care
2. The outcomes of the care set out in the plan of care
3. The effectiveness of the plan of care.

(11) When a resident is reassessed and the plan of care reviewed and revised,

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

**Findings:**

1. A resident was not assessed by the registered nurse after he / she physically assaulted another resident by wrapping the call bell cord around his/her neck. The same resident was verbally aggressive and uttering threats to smother another resident with a pillow. The attending physician, the director of care and both residents' family members were not notified until five days after the incidents of physical and verbal aggression which did not allow for further assessment and monitoring of the resident's behaviours.
2. The plan of care for the resident was not revised after both incidents.
3. The plan of care does not identify behavioural triggers related to the resident's physical and verbal aggression towards other residents. Behavioural management assessments, interventions and the use of par re nata (PRN) drugs are not identified in the resident's plan of care.
4. Registered nursing staff did not assess the resident's behaviours and review his /her plan of care after his /her transfer to another unit.
5. No assessment of the other resident's physical and psychological well being was done after the resident was physically assaulted and verbally abused / threatened.
6. There is no documentation in the resident's health care record regarding Zyprexa 5mg po HS being ordered, started, nor of its effect on the resident's behaviours. There is no documentation of the resident's transfer to another resident care unit and his /her associated behaviours on and after the transfer.
7. These incidents were reported via an internal e-mail from the registered nurse to the director of care five days after the incidents and thru the completion of a Critical Incident report filed to the MOHLTC by the director of care ten days after the incidents.

Compliance Order #001 was faxed to the licensee on October 22, 2010

| **Inspector ID #:** | # 117 |
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**WN #2:** The Licensee has failed to comply with the O.Reg. 79/10, 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:

3. Resident monitoring and internal reporting protocols.

**Findings:**

1. The registered nurse did not follow the long-term care home's internal reporting protocol in relation to both incidents of physical assault/ aggression and verbal aggression.

**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 regarding resident monitoring and internal reporting of critical incidents related to resident responsive behaviours to be implemented voluntarily.

| **Inspector ID #:** | # 117 |
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**WN #3:** The Licensee has failed to comply with the O.Reg. 79/10, s. 55, Every licensee of a long-term care home shall ensure that,

(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours,

including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

**Findings:**

1. The registered nurse did not document the incidents of physical and verbal aggression in the unit's 24-hour nursing report.
2. The registered practical nurse and health care aids state that they were not informed of the incidents of physical and verbal aggression at the shift report.

**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 regarding the need to advise direct care staff at the beginning of every shift of each resident whose behaviours pose a potential risk to the resident or others be implemented voluntarily.

| **Inspector ID #:** | #117 |
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**WN #4:** The Licensee has failed to comply with the LTCHA, 2007, c.8, s. 24 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

**Findings:**

1. The home did not immediately report first incident where a resident physically assaulted another resident by wrapping the call bell cord around his /her neck. A critical incident report was received by the MOHLTC ten days after the incident.
2. The home did not immediately report the second incident where a resident was verbally aggressive and uttering threats to smother another resident with a pillow. A critical incident report was received by the MOHLTC ten days after the incident.

**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 regarding the need to immediately report to the Director incidents of abuse that resulted in harm or a risk of harm to the resident to be implemented voluntarily.

| **Inspector ID #:** | # 117 |
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| Signature of Licensee or Representative of Licensee<br>Signature du Titulaire du représentant désigné | Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. |
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Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

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| | Lynn Duchesneau |
| Title: Date: | **Date of Report:** (if different from date(s) of inspection).<br>November 23, 2010 |

Ontario

**Ministry of Health and Long-Term Care**
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

# 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

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| | ☐ Licensee Copy/Copie du Titulaire | X Public Copy/Copie Public | |
| **Name of Inspector:** | Lyne Duchesne | **Inspector ID #** | 117 |
| **Log #:** | O-000920 | | |
| **Inspection Report #:** | 2010_188_9567_29Sep103811 | | |
| **Type of Inspection:** | Critical Incident | | |
| **Date of Inspection:** | September 29 2010 | | |
| **Licensee:** | United Counties of Prescott and Russell<br>59 Court Street<br>Box 304<br>L'Orignal, ON<br>K0B 1K0<br>FAX : 1-613-675-4547 | | |
| **LTC Home:** | Résidence Prescott et Russell<br>1020 Cartier Boulevard<br>Hawkesbury, ON<br>K6A 1W7<br>Fax: (613) 632-4056 | | |
| **Name of Administrator:** | 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:

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|---|---|---|---|
| **Order #:** | 001 | **Order Type:** | Compliance Order, Section 153 (1) (b) |

**Pursuant to:** The Licensee has failed to comply with : LTCHA 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

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

11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

**Order:** The licensee shall prepare, submit, and implement a plan for achieving compliance to meet the requirement that there is written plan of care for residents exhibiting responsive behaviours that demonstrates that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident, ensures that provision of care, the outcomes of the care provided and the effectiveness of the care are documented, and that the plan of care is reviewed and revised if care set out in the plan has not been effective.

**Grounds:**

1. A resident was not assessed by the registered nurse after he /she physically assaulted another resident, by wrapping the call bell cord around his / her neck. The same resident was verbally aggressive and uttering threats to smother the other resident with a pillow. The attending physician, the director of care and both residents' family members were not notified until five days after the incidents of physical and verbal aggression which did not allow for further assessment and monitoring of the resident's behaviours.
2. The plan of care for the resident was not revised after both incidents.
3. The plan of care does not identify behavioural triggers related to the resident's physical and verbal aggression towards other residents. Behavioural management assessments, interventions and the use of par re nata (PRN) drugs are not identified in the resident's plan of care.
4. Registered nursing staff did not assess the resident's behaviours and review his /her plan of care after his /her transfer to another unit.
5. No assessment of the resident's physical and psychological well being was done after the resident was physically assaulted and verbally abused / threatened.
6. There is no documentation in the resident's health care record regarding Zyprexa 5mg po HS being ordered, started, nor of its effect on the resident's behaviours. There is no documentation of the resident's transfer to another resident care unit and his / her associated behaviours on and after the transfer.
7. These incidents were reported via internal e-mail from the registered nurse to the director of care dated five days after the incidents occurred and thru the completion of a Critical Incident report filed to the MOHLTC by the director of care ten days after the incidents occurred.

| **This order must be complied with by:** | November 27 2010 |
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## 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 service for the Licensee.

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

**Director**
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

**Health Services Appeal and Review Board and the**
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

**Director**
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

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| Issued on this 22 day of October, 2010. | |
| Signature of Inspector: | Lyne Duchesne |
| Name of Inspector: | Lyne Duchesne |
| Service Area Office: | Ottawa |