



**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 sous la
Loi de 2007 sur 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**

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 18, 2016	2015_435621_0013	000611-16	Resident Quality Inspection

Licensee/Titulaire de permis

RIVERSIDE HEALTH CARE FACILITIES, INC.
110 VICTORIA AVENUE FORT FRANCES ON P9A 2B7

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

EMO HEALTH CENTRE
170 FRONT STREET P. O. BOX 390 EMO ON P0W 1E0

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

JULIE KUORIKOSKI (621), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 4,5,6,7,8,11 and 12, 2016.

Additional intakes completed during this inspection: #020709-15 related to following up on past due orders regarding exit doors and bed rails.

During the course of the inspection, the inspector(s) spoke with Manager of Care, Director of Environmental Services, Registered Nurses (RN), Registered Practice Nurses (RPN), Maintenance Worker, residents and family members.

Observations were made of resident care areas, provision of care and services to residents as well as staff to resident interactions. The home's health care records for several residents were reviewed, along with relevant policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:

Contenance Care and Bowel Management

Dining Observation

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Residents' Council

Safe and Secure Home

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

9 WN(s)

6 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)



The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 9. (1)	CO #001	2015_333577_0006		617

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
<p>WN – Written Notification</p> <p>VPC – Voluntary Plan of Correction</p> <p>DR – Director Referral</p> <p>CO – Compliance Order</p> <p>WAO – Work and Activity Order</p>	<p>WN – Avis écrit</p> <p>VPC – Plan de redressement volontaire</p> <p>DR – Aiguillage au directeur</p> <p>CO – Ordre de conformité</p> <p>WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>



**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:**

- s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
- (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
 - (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
 - (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

Findings/Faits saillants :



1. The licensee has failed to ensure that where bed rails are used, resident #001 was assessed and their bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy titled, "Bed Entrapment-Registered Staff Procedure", last revised March 8, 2013, which indicated that upon admission each resident must be assessed for potential risk for bed entrapment.

On January 12, 2016, Inspector #617 interviewed the Manager #102 who clarified that the resident bed rail assessment was to be completed on the Riverside Health Care, "Bed Rail Assessment Form" and compiled in a binder at the nursing station.

On January 5 and 8, 2016, resident #001 was observed to have bed rails up and a transfer sign above the bed which indicated the use of bed rails. Inspector #617 reviewed resident #001's quarterly Resident Assessment Inventory Minimum Data Set (RAI MDS) from October 2015, which indicated the use of daily bed rails. Review of resident #001's kardex indicated the use of bed rails and a safety device. A review of resident #001's care plan last updated in October 2015, did not indicate the use of bed rails.

On January 12, 2016, Inspector #617 interviewed RPN # 109 who reported that resident #001 used bed rails and a safety device when sleeping, and bed rails during the day for access to the call bell. Inspector #617 identified that there was not a completed bed rail assessment form for resident #001.

On January 7, 2016, Inspector #617 interviewed the Manager #102 who confirmed that resident #001 did not have a bed rail assessment completed on admission or at the time of this inspection. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

- s. 15. (2) Every licensee of a long-term care home shall ensure that,**
- (a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
 - (b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
 - (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home furnishings and equipment were maintained in a safe condition and in a good state of repair, specifically with regards to the air conditioner thermostat.

On January 4, 5, 6, 7, 8, 11, and 12, 2016, Inspector #617 observed an exposed copper couplet wire, cord and thermostat all connected to each other and hanging alongside the sill of a window in the dining room.

Inspector #617 interviewed maintenance staff #106 who reported that the exposed copper wire did not have electrical conductivity and was safe. The exposed system was connected to the air conditioner outside and was used to control the air conditioning for the building. At the time of inspection, the air conditioner was reported to not be operational.

Inspector #617 interviewed Director of Environmental Services #107 who clarified that in early summer of 2015, the thermostat on the wall was not functioning correctly to provide cool air to the building. The hanging thermostat was a temporary measure to control the air conditioner in order to provide cool air to the building and needed to be removed. Director of Environmental Services #107 also reported that a mechanical contractor had recently been secured to replace the air conditioner thermostat.

2. The licensee has failed to ensure that the home furnishings and equipment were maintained in a safe condition and in a good state of repair, specifically with regards to the boiler thermostat.

On January 5, 2016, Inspector #617 interviewed resident #006 who reported that their



room and their bathroom at times were cold in the morning and too hot in the evenings. As a result, resident #006 stated they were having to open the window in their room during the winter months.

Inspector #617 interviewed maintenance staff #106 who reported difficulties in maintaining an adequate room temperature for two resident rooms within the home. They identified that the heat for the home was controlled by a boiler and during the first week in December 2015, the thermostat on the boiler malfunctioned and since then they had to manually control the boiler temperature.

Inspector #617 interviewed the Director of Environmental Services #107 who confirmed that the boiler thermostat was not working and that maintenance staff #106 was responsible for manually setting the boiler. They reported that a replacement part for the thermostat had been ordered and they were waiting for its arrival. The Director of Environment Services #107 clarified that temperature monitoring for the home was centralized using a computer seven days a week between 0600hrs and 2200hrs. Any adjustments in temperature are communicated to the maintenance staff within the home to manage on site. The Director of Environmental Services #107 further stated that they were not aware of temperature control issues reported the two rooms identified by Inspector #617 and that he would investigate the issue further. [s. 15. (2) (c)]

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 with regards to ensuring the boiler thermostat and the air conditioning thermostat are maintained in a safe condition and in a state of good repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (1) Every licensee of a long-term care home shall ensure that a Residents' Council is established in the home. 2007, c. 8, s. 56 (1).



Findings/Faits saillants :

1. The licensee has failed to ensure that a Residents' Council is established in the home.

On January 4, 2016, Inspector #621 reviewed the home's completed copy of the "Entrance Conference Worksheet" with the Manager #102. When asked for the name of the Residents' Council President or active council member and their room location, it was reported that the home did not have a Residents' Council. They indicated that on request of the residents of the home that a coffee hour with the Manager and Activity Coordinator be offered instead on a quarterly basis. [s. 56. (1)]

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 a Residents' Council is established in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

- s. 59. (7) If there is no Family Council, the licensee shall,**
- (a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).**
 - (b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).**

Findings/Faits saillants :

1. The licensee has failed to ensure that if there is no Family Council that the licensee shall convene semi-annual meetings to advise such persons of the right to establish a Family Council.

During an interview with Manager #102 on January 4, 2016 it was reported that there was no Family Council in the home. They identified that the home holds an annual fish fry put on by the home at the end of August to advise families of their right to establish a Family Council. However, it was confirmed that the home does not convene meetings on a semi-annual basis to advise families of their right to establish a Family Council as per legislative requirements. [s. 59. (7) (b)]

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 if there is no Family Council, that the licensee shall convene semi-annual meetings to advise such persons of the right to establish a Family Council, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :



1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status.

Inspector #621 reviewed the homes weight record and it was identified that resident #003 had a significant weight change for a one month period between December 2015, and January 2016.

A review of the home's policy "Nutrition Consult - Long Term Care" identified that a nutrition consult was sent to the Registered Dietitian (RD) for further assessment in circumstances including 5 per cent weight change over one month. The homes "Nutrition and Hydration Program Policy" document also identified that changes in resident's condition and weight loss should be reported to the Physician and Registered Dietitian.

On January 7, 2016, Inspector #621 reviewed the contents of resident #003's chart and determined that no referral to the RD for the significant weight change had been made.

During an interview on January 7, 2016, RN #104 reported that the process for follow up on any significant weight and nutrition changes would involve the RN reviewing the weight change record found on the Kardex, and contacting the Physician for an order for referral to the RD.

During an interview with RN #104 they confirmed that the January 2016, weight was a significant weight change compared to the December 2015 recorded weight and verified that the Physician had not been notified and consequently no order had been made to refer the significant weight change to the RD for interdisciplinary assessment. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]



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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 with respect to ensuring residents with weight changes of 5 per cent or more over one month; 7.5 per cent or more over three months; 10 per cent or more over 6 months; and any other weight change that compromises their health status are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated, to be implemented voluntarily.

**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79.
Posting of information**

Specifically failed to comply with the following:

- s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
- (a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
 - (b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
 - (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
 - (d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
 - (e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
 - (f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
 - (g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
 - (h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
 - (i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
 - (j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
 - (k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
 - (l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
 - (m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
 - (n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
 - (o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
 - (p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
 - (q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :



1. The licensee failed to ensure that the required information for the purposes of subsections (1) and (2) was posted including copies of the inspection reports from the past two years for the long-term care home.

On January 4, 2016 Inspector #617 conducted a tour of the home and observed that the Long Term Care (LTC) Inspection reports for 2014 and 2015 were not posted in the home.

Inspector #617 interviewed the Manager #102 who confirmed that the LTC inspection reports dated 2014 and 2015 were not posted, and that they were not sure how long they had been missing from the bulletin board. [s. 79. (3) (k)]

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 copies of the inspection reports from the past two years for the long term care home are posted, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :



1. The licensee has failed to ensure that when residents #001, #003 and #004 were administered any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy entitled, "Pain Management Program", last revised April 2, 2013, which identified under statement #7, "Document the effectiveness of the interventions."

On January 6, 2016, Inspector #617 interviewed RN #104, who reported that registered staff document the effectiveness of administered analgesic for pain either on the back of the resident's Medication Administration Record (MAR) or in the progress notes. On January 12, 2016, Inspector #617 interviewed Manager #102 who clarified that it is the expectation of the registered staff to document the effectiveness of administered analgesic for pain on the MAR or in the progress notes.

Inspector #617 reviewed the health care record for resident #001 which included the December 2015 MAR and progress notes dated from October 2015, to January 2016, which indicated that the resident was administered medication for pain management. On four days in December 2015, the effectiveness of this medication was not documented in either the MAR or the progress notes. [s. 134. (a)]

2. Inspector #617 reviewed the health care record for resident #003 which included the December 2015 MAR and progress notes from December 2015, indicated that the resident was administered oral medication as needed for pain. On one day in December 2015, the effectiveness of this medication was not documented in either the MAR or the progress notes. [s. 134. (a)]

3. Inspector #617 reviewed the health care record for resident #004 which included the December 2015 MAR and progress notes dated in December 2015, indicated that the resident was administered topical medication as needed for pain on one day in December 2015, and another oral medication as needed for pain on five separate occasions in December 2015. The effectiveness of these medications was not documented for resident #004 in either the December 2015 PRN MAR or progress notes for the identified dates and times. [s. 134. (a)]



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 when residents are administered any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation or the resident's response and effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,

(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).

(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

On January 4, 2016, during a tour of the home, Inspector #617 observed in the tub room, personal items including one black comb with dandruff and three tubes of Tena protective cream that were used and unlabelled.

Inspector #617 interviewed staff #100 and #101, both members of the registered staff who provided direct resident care. They clarified that the unlabelled personal products in the tub room were used on those residents that don't have their own supply and are supplied by the hospital. [s. 37. (1)]



WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).

(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).

(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :



1. The licensee has failed to ensure that the Homes' Nutrition Care and Hydration Program measures and records with respect to each resident a height annually.

Upon review of the resident health records, it was found that an annual height was not recorded for nine residents in 2015.

During an interview January 6, 2016, RN #104 reported to Inspector #621 that heights are taken once on admission and only again if there was a significant change in height (eg., if resident had an amputation).

During an interview January 5, 2016, Manager #102 and RN #103 reported to Inspector #621 and #617 that heights to date had only been completed on admission. Further, the Manager #102 confirmed that it is a legislative requirement to complete annual heights and the home has not been completing these. [s. 68. (2) (e) (ii)]

Issued on this 2nd day of March, 2016

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

Original report signed by the inspector.



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
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*

**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**

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Name of Inspector (ID #) /

Nom de l'inspecteur (No) : JULIE KUORIKOSKI (621), SHEILA CLARK (617)

Inspection No. /

No de l'inspection : 2015_435621_0013

Log No. /

Registre no: 000611-16

Type of Inspection /

Genre

d'inspection:

Resident Quality Inspection

Report Date(s) /

Date(s) du Rapport : Feb 18, 2016

Licensee /

Titulaire de permis : RIVERSIDE HEALTH CARE FACILITIES, INC.
110 VICTORIA AVENUE, FORT FRANCES, ON,
P9A-2B7

LTC Home /

Foyer de SLD : EMO HEALTH CENTRE
170 FRONT STREET, P. O. BOX 390, EMO, ON,
P0W-1E0

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Ted Scholten

To RIVERSIDE HEALTH CARE FACILITIES, INC., you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and
Long-Term Care**

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

**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. 2007, chap. 8

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

Linked to Existing Order /
Lien vers ordre 2015_333577_0006, CO #002;
existant:

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

- (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
- (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
- (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

- 1) The licensee shall ensure that where bed rails are used, specifically for resident #001, and any other resident, that the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.
- 2) The licensee shall develop and implement an audit process to ensure compliance with this regulation.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, resident #001 was assessed and their bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy titled, "Bed Entrapment Registered Staff Procedure", last revised March 8, 2013, which indicated that upon admission each resident must be assessed for potential risk for bed entrapment.



**Ministry of Health and
Long-Term Care**

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*

**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. 2007, chap. 8*

On January 12, 2016, Inspector #617 interviewed the Manager #102 who clarified that the resident bed rail assessment was to be completed on the Riverside Health Care, "Bed Rail Assessment Form" and compiled in a binder at the nursing station.

On January 5 and 8, 2016, resident #001 was observed to have bed rails up and a transfer sign above the bed which indicated the use of bed rails. Inspector #617 reviewed resident #001's quarterly Resident Assessment Inventory Minimum Data Set (RAI MDS) from October 2015, which indicated the use of daily bed rails. Review of resident #001's kardex indicated the use of bed rails and a safety device. A review of resident #001's care plan last updated in October 2015, did not indicate the use of bed rails.

On January 12, 2016, Inspector #617 interviewed RPN # 109 who reported that resident #001 used bed rails and a safety device when sleeping, and bed rails during the day for access to the call bell. Inspector #617 identified that there was not a completed bed rail assessment form for resident #001.

On January 7, 2016, Inspector #617 interviewed the Manager #102 who confirmed that resident #001 did not have a bed rail assessment completed on admission or at the time of this inspection.

Non-compliance pursuant to LTCHA, 2007, Ontario Regulation 79/10, r.15. (1) was previously identified under inspection report 2014_211106_0007 where a VPC was issued, and 2015_333577_0006 where a compliance order was served on May 27, 2015.

A decision to re-issue this compliance order was based on the scope which was isolated; the severity which indicated a potential for actual harm and the compliance history, which despite a previous compliance order has continued to be non-compliant with this area of the legislation.

(617)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2016



**Ministry of Health and
Long-Term Care**

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

**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. 2007, chap. 8



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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 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



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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

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.



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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, 11^e étage
Ontario, ON
M5S-2B1
Fax: 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.



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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 :

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
Ontario, ON
M5S-2B1
Fax: 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 18th day of February, 2016

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :** Julie Kuorikoski

**Service Area Office /
Bureau régional de services :** Sudbury Service Area Office