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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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 23, 2017	2017_624196_0001	034966-16	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

LAUREN TENHUNEN (196), KATHERINE BARCA (625)

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 16, 17, 18, 19 and 20, 2017

The following intake was inspected concurrently:

A follow up related to a Compliance Order for bed rail assessments.

During the inspection, the Inspectors conducted a walk-through of resident care areas, observed staff to resident interactions and the provision of care and services to residents, and reviewed several resident health care records.

During the course of the inspection, the inspector(s) spoke with the Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), the Registered Dietitian (RD), residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 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 # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_435621_0013	196

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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During stage one of the inspection, resident #003 was identified as requiring further inspection regarding bed rails that were observed in the guard position and potentially functioning as a restraint device.

The health care record for resident #003 was reviewed for information regarding the use of bed rails. The most recent bed rail assessment identified the use of a specific number of bed rails. The current care plan, as located in the care plan binder, did not reference the use of bed rails.

Inspector #196 conducted interviews with RPN #101 and RPN #102, who reported that a specific number of bed rails were to be used when the resident was in bed to prevent the resident from rolling out of bed. RPN #102 acknowledged that the resident's care plan did not identify the use of bed rails.

An interview was conducted with the Manager, who reported the care plans, as located in the care plan binder, were where staff were to obtain information about a resident's care needs. [s. 6. (1) (c)]

2. During stage one of the inspection, resident #003 was identified as requiring further inspection regarding a low body mass index (BMI) without a plan, as identified during a staff interview.

The health care record for resident #003 was reviewed for information regarding nutritional status.

The current care plan, as documented in Goldcare and in the care plan binder, identified a specific diet type with a specific diet texture. The care plan did not identify a specific diet texture for a particular type of food.

The diet list dated on a particular date, as located in the flow sheet binder, identified a specific diet type with a specific diet texture for a particular type of food. The resident preferences, including likes and dislikes were noted.

The diet list dated approximately one month later, as posted in the servery identified the same specific diet type with the same specific diet texture for a particular type of food.

Inspector #196 conducted an interview with RPN #101 who reported that it would depend on the type of meal that would determine whether a particular type of food was processed into a different texture or not. The RD reported that the resident was to receive a specific diet type with a specific diet texture for a particular type of food. An interview was conducted with the Manager, and they stated that the staff were to decide what was best for the resident to eat, with regard to the diet texture. [s. 6. (1) (c)]

3. During stage one of the inspection, resident #004 was identified as requiring further inspection regarding bed rails that were observed in the guard position and potentially functioning as a restraint device.

Inspector #196 observed resident #004 lying in bed, on a specific day during the inspection, with particular bed rails in the guard position. On another date during the inspection, Inspector #196 observed resident #004 lying in bed with particular bed rails in a different position.

The health care record for resident #004 was reviewed for information regarding the use of bed rails. The most recent bed rail assessment identified the use of specific bed rails. The current care plan as located in care plan binder, identified the use of bed rails for an activity of daily living but did not specify which type of bed rails were to be used.

Inspector #196 conducted interviews with RPN #101 and RPN #102, who reported that specific bed rails were to be used in a specific position. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

During stage one of the inspection, resident #005 was identified as having a low BMI without a plan, as identified during a staff interview.

The health care record for resident #005 was reviewed. The most recent Minimum Data Set (MDS) assessment indicated a low BMI. The current care plan, as found in the care plan binder, did not include a focus of nutrition based upon the BMI score.

Inspector #196 conducted an interview with RPN #102 and they acknowledged that the care plan, as found in the care plan binder, did not include a focus of nutrition based upon a nutritional assessment, but should have. An interview was conducted with RPN #105 who reported that new resident information was shared during shift report. In addition, they would look at the written care plan as found in the care plan binder, for information about a resident.

An interview was conducted with the Manager, who reported that the care plans, located in the care plan binder, was where staff were to obtain information about a resident's care needs. [s. 6. (2)]

5. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

During stage one of the inspection, resident #003 was identified as requiring further inspection regarding a low BMI without a plan, as identified during a staff interview.

The health care record for resident #003 was reviewed for information regarding nutritional status. The current care plan, as found in the care plan binder, included a specific dietary intervention. The dietary reference sheet in the flow sheet binder and as posted in the servery included this specific dietary intervention. The most recent Registered Dietitian (RD) progress note, identified the specific dietary intervention.

Inspector #196 conducted an interview with RN #104 who reported that they were not sure when resident #003 was last provided the specific dietary intervention. RPN #101 reported that the resident had not received this specific dietary intervention for as long as they could recall.

An interview was conducted with the Manager who reported that resident #003 had been refusing the specific dietary intervention since their admission to the home.

An interview was conducted with the RD who reported that they were unaware resident #003 had not been receiving the specific dietary intervention. The most recent RD progress note identified the specific dietary intervention and the RD reported they were not aware that the specific dietary intervention was not being given, and had not received this information from the home's staff. [s. 6. (4) (a)]

6. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

On a particular day during the inspection, Inspector #625 reviewed resident #007's Medication Administration Record (MAR) for the 0800 hrs medication pass which included specific types of medication to be applied to the resident.

On the following day, during an observation of the 0800 hrs medication pass for resident #007, Inspector #625 heard the resident state to RPN #101 that the specific types of medication to be applied to the resident's had already been applied.

During a review of resident #007's MAR following the administration of the resident's 0800 hrs medication pass, Inspector #625 noted that the specific types of medication to be applied to the resident had not been signed for.

During an interview with Inspector #625, RPN #101 stated that they did not apply the specific types of medication to resident #007 as listed in the MAR as the resident stated that it had been completed earlier by a Registered Nurse (RN) on the previous shift. The RPN stated that the application of the specific types of medication to be applied to the resident were not signed for on the MAR and they would have to check to see if it had been done by looking at the resident.

During an interview with Inspector #625, RN #104 stated that resident #007 had the treatment done which included the application of the specific types of medication by the previous shift, as reported in change of shift report. The RN acknowledged that the MAR had not been signed for by the previous shift to identify that the specific types of medication were applied to the resident.

During an interview with Inspector #625, the Manager stated that the change of shift report had indicated that resident #007's treatment had been completed by RN #106 on the previous shift. The Manager acknowledged that the application of the specific types of medication to be applied to the resident as listed on the MAR had not been signed for by the RN, although they had been applied. [s. 6. (9) 1.]

7. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan was no longer necessary.

Resident #001 was observed during the inspection lying in bed with the bed rails not in use.

The health care record for resident #001 was reviewed for information regarding the use of bed rails. The most recent bed rail assessment indicated, under the comments section, that a specific type of bed rail was used for the resident.

Inspector #196 conducted an interview with RPN #102 and they reported that the bed rails were no longer used as they were more of a hindrance to the resident and it had been approximately six to 12 months since the bed rails had been used. [s. 6. (10) (b)]

8. During stage one of the inspection, resident #005 was identified as having had a fall within a previous specific time period.

On a particular day during the inspection, Inspector #196 observed resident #005 seated in a wheelchair with a specific type of fall prevention device in operation and another type of fall prevention device not in place.

Inspector #196 conducted an interview with RPN #101 and they reported that resident #005 refused to use one fall prevention device.

Inspector #196 conducted an interview with RPN #102 and they reported that the resident refused to use the fall prevention device and upon review of the care plan, acknowledged that that the other specific type of fall prevention device, which had been observed in operation, was not reflected in the care plan.

The health care record for resident #005 was reviewed. The current care plan, as located in the care plan binder, indicated under the focus of "risk of injury from falls" that the resident was to have a fall prevention device on while in a mobility device when up, and there was no reference to the use of the other specific type of fall prevention device. [s. 6. (10) (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 that ensures that there is a written plan of care for resident #003, #004 and #005, that sets out, clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

On a specific day during the inspection, Inspector #625 observed medications located on resident #007's night stand.

On a specific day during the inspection, during an interview with Inspector #625, resident #007 showed the Inspector medications they kept in their nightstand drawer.

During an interview with Inspector #625, RPN #101 stated that they were not aware of any residents in the home who self-administered medications. The RPN further stated that they were aware that resident #007 had some medications at their bedside but stated that the medications should be kept on the medication cart. The RPN was not able to locate an order from the physician that indicated that resident #007 was authorized to self-administer the medications at their bedside.

A review of resident #007's physician's orders, including a "Three Month Review" and subsequent physician's orders, did not identify physician's orders for the self-administration of the medications at the resident's bedside.

During an interview with Inspector #625, the Manager stated residents were required to have a physician's order for self-administration of medications. The Manager was not able to locate a physician's order in the resident's chart that indicated that the resident could self-administer the medications at their bedside.

A review of the home's policy "Medications at Bedside in LTC Procedure" (no index number, undated) provided by the home's Manager, indicated that staff were to obtain a physician's order to allow medication to be left at the bedside. [s. 131. (5)]

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 that ensures no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, the following: review, subject to compliance with subsection 71(6), of meal and snack times by the Residents' Council.

During an interview with Inspector #625, a member of the Residents' Council, resident #008, stated that they believed that having the residents' lunch scheduled for 1130 hours was too early and too close to the residents' breakfast meal.

A review of the posted Residents' Council meeting minutes dated July 22 and October 21, 2016, did not identify that the council had reviewed the meal and snack times.

During an interview with Inspector #625, the home's Manager stated that they were not aware that the meal and snack times had ever been discussed with the Residents' Council, and that the home had always had the same times in place since they had worked in the home. The Manager stated they would contact the home's Food Services Supervisor (FSS) #100 to determine if the FSS had discussed the times with the Residents' Council.

During a second interview with Inspector #196, the home's Manager stated that they had spoken to the FSS #100 who had stated that they did not recall ever speaking with the residents regarding times of snacks and meals. [s. 73. (1) 2.]

Issued on this 27th day of February, 2017

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

Original report signed by the inspector.