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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 15, 2019	2019_624196_0023	018257-19	Other

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): September 30 - October 3, 2019.

This inspection is a Sudbury Service Area Office initiated inspection.

Inspector #757 attended this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Residents.

During the course of the inspection, the Inspectors conducted a walk through of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed several resident health care records, and reviewed various home programs, policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Medication
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the skin and wound care program, was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During the inspection, resident #001, resident #003 and resident #004 were identified as having areas of altered skin integrity.

The home’s policy titled "Skin and Wound Care Program", undated, identified the use of a wound care flow sheet/ treatment record for wound assessment; the use of "Appendix D: Pressure Ulcer/Wound Assessment Record" as a clinically appropriate assessment instrument; and "Appendix E: Staging of Wounds" to stage a pressure injury.

In a review of the identified residents' health care records, a wound care flow sheet or treatment record could not be located.

In an interview with RN #104, they reported that a progress note was to be documented at every dressing change; and there was no wound care flow sheets or treatment records to be used.

In an interview with RPN #105, they reported that they would make a note in Point Click Care (PCC) of a dressing change; and the home did not have a wound care treatment form for use.

During an interview with the Administrator/DOC, they confirmed there was no wound care flow sheet/treatment record in use as indicated in #14 of the policy, and reported a progress note was to be done for every dressing change. They further indicated that Appendix D and E as in the policy were not in current use by the home. In addition, the home’s policy on skin and wound had not been evaluated and updated at least annually and was last done in 2014. [s. 30. (1) 3.]

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 the skin and wound care program, is evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to be implemented voluntarily.

WN #2: 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 has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During the inspection, resident #002 was identified as having an unwitnessed fall on a specified date in 2019, which resulted in a transfer to the hospital for an injury.

The home's policy titled "Falls Prevention and Management Program: Post Falls Assessment and Management: Registered Nursing Staff Procedure - #DEP-NUR-GEN-F-25" was reviewed. According to this policy, nursing staff were to "complete the Post Falls Screening tool and/or Risk assessment in the EMR to assist in identifying possible contributing factors".

In a review of resident #002's health care records, a paper document titled "Post Fall Screen for Resident / Environmental Factors" dated on the same date as the fall, was located. The document was completed in pencil, was unsigned by the nursing staff and several areas were incomplete.

In an interview, RPN #101 indicated that the Morse Fall Scale was to be used as a post falls assessment; and they had concerns regarding this tool, as it was used to determine the risk of falls rather than a specific clinically appropriate falls assessment or identification of specific interventions to prevent falls. They further added that this issue of a post falls assessment was ongoing in discussions with the Administrator/DOC.

In an interview, the Administrator/DOC reviewed the "Post Fall Screen for Resident/Environmental Factors" for resident #002. They confirmed this document was not completed in entirety; it was not signed; had been completed in pencil; and the Morse fall scale was not completed until approximately two and a half weeks following the fall. [s. 49. (2)]

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 when a resident had fallen, the resident is assessed and that where the condition or circumstances of the resident requires, a post-fall assessment is conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

At the time of the inspection, resident #001 was identified as having an area of altered skin integrity.

In a review of the home's policy titled "Skin and Wound Care Program", undated, it indicated that "All wounds will be assessed on the resident's 1st bath day of the week, completing the Wound Care Flow Sheet/Treatment Record form, including size (circumference and depth) of the wound, discharge form the wound, appearance, progression, pain, equipment being used, etc. eg.: Vac. dressing and the response to treatment within 7 to 10 days of initiation."

In a review of resident #001's health care records, a Wound Care Flow Sheet/Treatment Record could not be located.

During an interview with RPN #101, they reported that Wound Care Flow Sheets or Treatment Records were no longer used after changing to Point Click Care (PCC). They further added that progress notes in PCC were to be used when there were abnormalities and the daily dressing treatments were to be recorded in the Medication Administration Record (MAR).

In an interview, RN #102 indicated that dressing changes were to be recorded on the MAR, and indicated that weekly wound assessments were completed in PCC.

During an interview with the Administrator/DOC, they reported that residents with altered skin integrity and wounds should have had weekly assessments documented in a progress note. They confirmed there was no wound care flow sheet/treatment record in use as indicated in #14 of the policy; there should have been a wound care assessment in PCC for staff to use and had requested for a tool to be added but it had not been. [s. 50. (2) (b) (iv)]

2. A review of additional resident's health care records regarding altered skin integrity, was conducted.

Resident #003 was identified with an area of altered skin integrity.

The resident's health care record was reviewed and a weekly wound assessment was not located. The most recent progress note regarding this area was documented approximately one month prior to the date of inspection.

Resident #004 was identified to have an area of altered skin integrity.

The resident's health care record was reviewed and a weekly wound assessment was

not located. The most recent progress note regarding this area was documented approximately two weeks prior to the date of inspection. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that precluded exit by a resident, including balconies and terraces, or doors that residents did not have access to were kept closed and locked.

During the initial tour of the home, Inspector #196 and Inspector #757 observed an unlocked door outside of the main dining room, which led to a stairway that exited the home.

Together with the Inspectors, RPN #101 observed the noted door that led to a stairway. They confirmed that the door should have been locked.

In an interview with the Administrator/Director of Care (DOC), they reported that this door that led to a stairway was to be locked at all times as it led to an area with stairs, and was unsafe for residents. [s. 9. (1) 1. i.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, if the Residents' Council had advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

A review of the last six months Residents' Council meeting minutes was conducted by the Inspector. In the May 2019 meeting minutes, a concern regarding the gazebo doorway had been brought forward.

During an interview with the Administrator/DOC, they reported that they had responded personally to the resident that had brought forward the concern and had not responded to the council in writing. [s. 57. (2)]

WN #6: 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: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. 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 elements: Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat.

Observations of the lunch service in the main dining room was conducted by Inspector #757 and Inspector #196. Resident #001 and resident #007 were observed eating their meals while seated at their tables. Both resident's were in a low position, relative to the dining table top, at the level of the resident's clavicle.

During another observation, resident #008 was seated at their table and had a specific intervention in place to assist with their meal.

In an interview, resident #001, when asked about the height of the dining room table, they made a specific statement regarding the table height.

During an interview, RPN #101 reported that adjustable dining room tables had been requested in the past by the Administrator/DOC.

During an interview with the Administrator/DOC, they reported the dining tables had been an issue for several years; they had requested tables that adjust; they included them in the capital budget request for the past two years and they had been denied. They further reported that recently the new senior management came to see the home and did a tour and saw the tables, and said they would get this addressed in the new year. With regard to resident #008, they reported the resident felt a certain way with the situation and they were becoming more affected and it was not an ideal situation. [s. 73. (1) 11.]

Issued on this 15th day of October, 2019

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

Original report signed by the inspector.