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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Dec 18, 2015	2015_339617_0021	026484-15	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

RAINY RIVER HEALTH CENTRE
114 FOURTH STREET P.O. BOX 236 RAINY RIVER ON P0W 1L0

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

SHEILA CLARK (617), JENNIFER KOSS (616)

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): October 5, 6, 7, 8, 9, 13, 14, 15, 2015

During the course of the inspection, the inspector(s) spoke with the Manager of Nursing Services, Director of Food Services, Food Service Supervisor (FSS), Head Cook, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), President of the Residents' Council, President of the Family Council, family members and residents.

During the course of the inspection, the inspector(s) completed a tour of the residents' home area, observed meal service, observed medication administration, reviewed infection control practices , reviewed policies and procedures and observed resident care and services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **4 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. 9. (1)	CO #001	2015_339617_0005	617

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system, related to quality improvement was complied with.

Inspector #617 reviewed the Riverside Health Care policy titled "Quality Management Procedure" (no date for revision) which indicated the following:
1. Each program will be evaluated annually utilizing standardized tools and according to the schedule for evaluation
2. Each team will use the program evaluation form to evaluate the program. This will include the date of evaluation, names of persons who participated, a summary of the changes made and the date that those changes were implemented.
3. Goals of the program must be established each year. The goals must be SMART goals.

Inspector #617 reviewed the Riverside Health Care policy titled "Quality Management Program", (no date for revision) which indicated the following:
Managers of care are responsible for ensuring that Quality Management Program is completed. This may include audits, surveys, and meetings.

On October 08, 2015, the Nurse Manager submitted to inspector #617 the "2015/16 Quality Improvement plan for Ontario Long Term Care Homes-Improvement Targets and Initiatives" which indicated current performance with regards to nursing programs such as falls, pressure ulcers, restraints, worsened bladder control and use of anti-psychotics reductions. However, there were no planned improvement initiatives indicated in the report.

On October 08, 2015, inspector #617 interviewed the Nurse Manager, who reported that she hasn't presented the quality improvement plan to the Family Council because she has not yet put an improvement plan in place.

The home failed to comply with their own Quality Improvement policy. [s. 8. (1) (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 the the home's Quality Improvement policy to improve the overall care and services for residents living in the home, is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing residents' #005, #009, and #010, care was held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker.

Resident #005's family member reported to inspector #616 that they had not received an invitation to participate in an annual care conference. The inspector reviewed the health records for residents #005, #009 and #010, and found no documentation related to an interdisciplinary team care conference since their admission date.

In the home's Resident's Handbook provided by the Nurse Manager, "Annual Multidisciplinary Care Review", page 24, indicated the Multidisciplinary Care Review (MCR) will take place within 4 weeks of admission and annually thereafter. Inspector reviewed the home's departmental policy "Family Conferences" which also states a family conference will be held within six weeks of the resident's admission to the facility, annually, and as required or requested to discuss changes to the resident's condition.

The Nurse Manager confirmed that initial and annual care conferences have not been held for residents: #005, #009, and #010. Resident #005 has missed two annual care conferences, and both residents #009 and #010 have missed their initial six week care conference.

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 care conference of the interdisciplinary team providing residents' #005, #009, and #010, care is held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, to be implemented voluntarily.

WN #3: 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 failed to ensure a monitoring system that measured and recorded each resident's height upon admission and annually thereafter was implemented.

Inspectors #616 and #617 reviewed documentation for the residents' height measurements. The inspectors reviewed residents' electronic health records and identified that the annual height documentation since admission was missing for residents, #002, #010, #011, and #012. In an interview with S #101 on October 6, 2015, they stated to inspector #616 that a resident's height was to be obtained on admission and documented in the resident's electronic health record.

On October 14, 2015, S #110 and inspector #616 reviewed the kardex as well as the electronic health records for residents, #002, #010, #011, and #012, and found no height documentation from their admission date to October 14, 2015. A review of the resident health care records indicated the following:
-resident #002 had no height measurement for 11 months
-resident #010 had no height measurement for 10 months
-resident #011 had no height measurement for two months and
-resident #012 had no height measurement for two months.

Inspector #616 interviewed the nurse manager who stated that a resident's height would be obtained on admission only. Inspector #616 reviewed the home's "Hydration and Nutrition Program Procedure, Registered Nursing Staff Procedure" last updated on June 17, 2013, which indicated that the resident's height and Body Mass Index was to be recorded upon admission and annually thereafter. The Nurse Manager reviewed the home's internal policies for a more recent version, found none, and confirmed residents' #002, #010, #011, and #012 heights have not been measured annually.

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 a monitoring system is in place to measure and record heights for residents' #002, #010, #011, and #012 on an annual basis, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the persons who have received training in the home's policy to promote zero tolerance of abuse and neglect of residents, received retraining in this area annually as provided for in the regulations.

On October 7, 2015, inspector #617 interviewed resident #002 who reported that during provision of care a staff member was rough and spoke rudely. Resident #002 informed the inspector that they didn't report the incident.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy titled "Abuse and Neglect Zero Tolerance" with a printed date of February 22, 2013, which indicated the following procedure regarding staff training:
"All staff must receive training on hire and annually thereafter on the Resident's Bill of Rights including the power imbalance between staff and residents and the potential for abuse and neglect by those in a position of power and responsibility".

On October 14, 2015, inspector #617 interviewed S #112 and registered staff S #111, regarding their knowledge of the prevention of resident abuse. Both S #112 and S #111 reported to the inspector that they have received training on "Gentle Persuasive Approach" which taught them how they were to manage resident responsive behaviours. S #112 described their knowledge regarding zero tolerance of abuse and neglect of residents as how they would handle aggressive residents. A member of the registered staff, S #111, reported that they were over due for training related to resident abuse and neglect.

On October 14, 2015, inspector #617 interviewed the Nurse Manager who confirmed that staff have not been trained annually regarding zero tolerance of abuse and neglect of residents. The "Gentle Persuasive Approach" training has been offered to the staff every four years which provided training on the management of responsive behaviour.

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 that the persons who have received training in the home's policy to promote zero tolerance of abuse and neglect of residents, receive retraining in this area annually as provided for in the regulations, to be implemented voluntarily.

WN #5: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for resident #006 that set out clear directions to staff and others who provide direct care to the resident.

Inspector #616 reviewed the Resident Assessment Instrument-Minimal Data Set (RAI-MDS) quarterly review related to nutrition for resident #006, which noted staff were to provide the resident with a specific nutritional supplement at night time (HS) and with meals. Inspector #616 reviewed the progress notes signed by the Registered Dietitian (RD) which confirmed that resident #006 was to be administered a specific nutritional supplement at HS and with meals.

On October 14, 2015, the inspector met with both S #110 and S #111 who each

identified by reviewing resident #006's Medication Administration Record (MAR), that the resident received the special nutritional supplement with medications administered by registered staff four times a day. The inspector and both staff reviewed the current "Diet Spread Sheet" for resident #006 which indicated that the resident was to receive the special nutritional supplement at HS and meals. S #110 and S #111 confirmed that this was unclear direction for the administration of the nutritional supplement to resident #006.

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as specified in their plan.

Inspector #616 reviewed resident #007's health record nutritional documentation for the resident. The care plan for resident #007 indicated that special monitoring and documentation of meal consumption was to be completed on their nutrition flow sheet as ordered by the RD.

Inspector #616 reviewed the home's "Nutrition and Hydration Program Policy" (#P-VI-3) which indicated that the residents' daily nutrition and hydration needs were met through monitoring of residents' weight, food and fluid intake. The RD explained to the inspector that the nursing staff recorded resident #007's daily food and fluid intake on the "Nutritional Record" and were to report any concerns to the RD.

S #112 and S #108 both confirmed to Inspector #616 that it was their responsibility to record the daily food and fluid intake for the residents on one of two forms: the Daily Resident Care Record; or the Nutritional Record. Both records were used for resident #007 as a concern was identified by the RD which required staff to monitor and document the resident's breakfast, lunch, supper and nourishment intakes.

Inspector #616 reviewed resident #007's Nutritional Records and found missing documentation for breakfast and lunch six out of seven days.

The inspector reviewed the missing documentation with S #102 and S #100 who each confirmed that the food and fluid intake monitoring for resident #007 had not been completed as required.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included alternate choices of entrees, vegetables and desserts at lunch and dinner.

Inspector #616 observed supper service in the dining room on October 5, 2015. The posted supper entrée choices were chicken pot pie and tuna salad sandwich. S #104 reported to the inspector that the only entrée that was available to the residents requiring a pureed texture was the chicken pot pie, with no alternate choice. On October 6, 2015, S #103 also stated that there was only one option for pureed texture at the supper service on October 5, 2015.

The Food Service Supervisor and Director of Food Services both stated that all entrees are available in alternate textures and confirmed the tuna sandwich should have been available as an alternate option but was not.

2. The licensee has failed to ensure that the evening meal was not served before 1700hrs.

Inspector #616 observed the supper meal in the dining room on October 5, 2015, which was served to the resident at 1645hrs. S #105 confirmed the meal service started at 1645hrs and reported that the meal service is scheduled for 1700hrs. On October 6, 2015, Inspector interviewed S #103 who reported that when staff are ready they will serve supper early but it usually starts at 1700hrs.

The inspector reviewed page nine of the Resident's Handbook which reads: "Meals are served at 0800hrs, noon and 1700hrs."

On October 8, 2015, the Director of Food Services and the Food Services Supervisor both confirmed to the inspector that the supper service is scheduled for 1700hrs and were unaware of the earlier service on October 5, 2015.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice from Residents' Council was sought in developing and carrying out the satisfaction survey.

Inspector #616 met with the Residents' Council President on October 14, 2015, who reported that the council was not involved in the development and carrying out of the satisfaction survey.

The Nurse Manager was unable to produce to inspector #616 any record to support their verbal report that Council had been involved in the development of the satisfaction survey.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a physical device to restrain resident #003 under section 31 of the Act was documented in accordance with monitoring, including the resident's response.

On October 6, 2015, inspector #617 observed resident #003 sitting in the wheelchair with a restraint applied.

Inspector #617 reviewed the health care records for resident #003 which indicated that they were assessed and fitted for the use of a wheelchair by the occupational therapist. The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) confirmed that resident #003 mobilized on the unit in their wheelchair. Resident #003's use of the restraint while seated in the wheelchair for safety was documented, ordered by the physician and consented to by the family.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy, titled "Direct Care Provider Application of a Restraint Procedure" which indicated under bullet #6 that documentation of the resident restraint monitoring in the record was required by the registered staff.

Inspector #617 reviewed the restraint monitoring records for resident #003 which indicated that the application, repositioning, removal and check was to be documented hourly and daily. There was missed documentation regarding the restraint monitoring, including the response, hourly checks, and repositioning for resident #003 for six consecutive days.

Inspector #617 interviewed registered staff #100, who confirmed that resident #003 had missed documentation of the restraint monitoring for the use of the pelvic restraint while in the wheelchair. Registered staff S #100 confirmed the use of the pelvic restraint for resident #003 which was established after a recent fall in September and currently is used for safety and fall prevention.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure drugs that were stored in an area or a medication cart, complied with manufacturer's instructions for the storage of the drugs.

Inspector #617 observed three 350ml bottles of Diovol Plus 20%, unopened, stored in the cupboard in the locked medication room. The expiry date on one of the bottles was February 2015. Registered staff, S #100 confirmed that the bottle of Diovol was expired.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy titled "Medication Management-Drug Destruction and Disposal Policy", last updated on March 12, 2014, which indicated that as part of the medication management system, the home was to provide for the ongoing identification, destruction and disposal of all expired drugs. Registered Nursing staff procedure indicated that all expired drugs shall be put for destruction or disposal.

On October 08, 2015 inspector #617 interviewed S #100, who reported that it was the night RPN's duty to clean out the medication room on the resident care area which included the disposal of all expired medication. S #100 then showed inspector #617 a document titled, "End of the Month Cleaning Checklist" dated for the year of 2015, which identified that the resident care area medication room was to have the expired medications disposed of by the RPN. The documentation of RPN initials indicated the task was completed.

Inspector #617 reviewed the document titled "End of the Month Cleaning Checklist" dated for the year of 2015, which indicated that for the following months no initials were present:
-January
-March
-April
-June
-July
-August
-September.

On October 8, 2015, inspector #617 interviewed the nurse manager, who reported that it was the expectation of the home for the RPN to have disposed of the expired medication in the medication room at the end of the month. The nurse manager confirmed that the disposal of the expired medications was not completed for the months not initialed on the "End of the Month Cleaning Checklist".

Issued on this 29th day of December, 2015

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

Original report signed by the inspector.