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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2017	2017_624196_0014	016077-17	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

LAUREN TENHUNEN (196), JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 2 - 5, 10 - 12, 2017.

The Inspectors also conducted a daily 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 several licensee policies, procedures and programs.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Financial Clerk, Registered Dietitian (RD), Pharmacist, President of the Resident and Family Councils, family members and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Resident Charges
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **6 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	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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: health conditions, including allergies, pain, risk of falls and other special needs.

During the inspection, Inspector #196 completed a review of resident #004's health care record as they were identified as having a change in pain frequency or intensity, through a Minimum Data Set (MDS) assessment. Inspector #196 noted that on a specific date in 2017, the MDS assessment identified pain. The MDS assessment dated approximately six weeks later, identified a different intensity of pain.

The current care plan was reviewed by Inspector #196 and there was no pain focus or interventions aimed at addressing resident #004's pain.

During the inspection, Inspector #196 interviewed RPN #107, who reported to the Inspector that resident #004 was prescribed an analgesic regularly, as well as an analgesic every four hours as required for pain, and identified that this resident had received a dose of an analgesic on a particular date.

On a date during the inspection, an interview was conducted with the Administrator/Director of Care and they confirmed to Inspector #196 that there was no plan of care related to pain for resident #004 and there should have been, as the resident was being administered a specific type of medication for pain. [s. 26. (3) 10.]

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 plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: health conditions, including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

During the inspection, Inspector #196 conducted a review of resident #003's health care records as they had been identified as having greater pain frequency or intensity according to the most recent MDS assessment when compared to the previous assessment.

Inspector #196 reviewed the health care records for resident #004. The MDS assessment dated on a specific date in 2017, identified pain. The MDS assessment dated approximately three months later, identified pain. Additionally, the most recent pain assessment as found in Gold Care was completed on a specific date in 2017. Further, there were three progress notes with the focus of "pain", over a four month period in 2017, which included:
- one note identifying expressions of discomfort when provided with a particular type of personal care;
- a second note identifying new orders received for pain management, and that they would monitor as needed; and
- a third note dated on a specific date in 2017, identified that the resident was indicating discomfort during care.

During a review of the Medication Administration Record (MAR), Inspector #196 identified that resident #003 had been receiving a specific analgesic medication three times daily up until a particular date in 2017, when a new physician's order for a specific analgesic medication four times a day was initiated and that the effectiveness was to be noted by the staff in one month. A note from the nursing staff for the physician indicated pain with a certain type of movement to particular parts of the resident's body.

During the inspection, Inspector #196 conducted interviews with PSWs #105 and #106 who both reported that resident #003 demonstrated pain with a certain type of movement. Additionally, RPN #108 reported to the Inspector that this resident would sometime express pain with a different presentation during care.

According to RPN #101, the pain assessments were to be completed quarterly and prior to the completion of the Resident Assessment Instrument (RAI) MDS quarterly assessments; they confirmed to the Inspector that there had not been a pain assessment completed since early 2017.

During the inspection, Inspector #196 conducted an interview with RPN #109 who reported that resident #003 would express pain on their face and even verbalize their pain sometimes.

An interview was conducted with the Administrator/Director of Care, who confirmed that there should have been a pain assessment completed quarterly; furthermore, pain assessments should have been conducted as it related to this resident's change in pain status, and with the increase in analgesia in a particular month in 2017. [s. 52. (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 that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: 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 that had a weight change of five per cent body weight, or more, over one month, a change of seven and one-half per cent body weight, or more over three months, or a change of ten per cent of body weight, or more, over six months, were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

On a date in October 2017, during a review of weight loss indicated from resident #001's most recent MDS, Inspector #621 identified a specific amount of weight change over a one month period, in late spring 2017. Additionally, the Inspector reviewed resident #001's health record and was unable to find documentation identifying that the home's Registered Dietitian (RD) had been notified.

Inspector #621 reviewed the home's policy titled "Nutrition and Hydration Program Procedure – Registered Nursing Staff Procedure" with no revision date, which indicated that Registered Nursing staff were to ensure that all monthly weights of residents were documented in Gold Care by the seventh of the month, and that an automatic email notification was generated from Gold Care to notify the Director/Manager of Care and Registered Dietitian (RD) of any significant weight changes.

During an interview, on a date in October 2017, RPN #101 reported to Inspector #621 that residents were weighed by the PSW and/or RPN staff on the first of every month, and that weights were subsequently entered into the weight record in Gold Care by the RPN on duty. RPN #101 indicated that if there was a significant weight change, that an

email notification would be generated by Gold Care to the Administrator/Director of Care (DOC) and RD for their review.

During interviews on two dates in October 2017, the Administrator/DOC reported to Inspector #621 that it was their expectation that weights were taken of residents on the first of the month by the PSWs and/or RPNs, and that the RPNs recorded the monthly weights into Gold Care. Additionally, the Administrator/DOC reported that once the weights were entered into Gold Care, it was expected that an automatic email notification was generated and sent to both the Administrator/DOC and RD, with the RD expected to follow up on any identified weight changes. The Administrator/DOC confirmed that there was no process to verify whether an electronic email notification was received by the RD for the identified weight change prior to their next visit to the home.

During an interview with the RD on a subsequent date in October 2017, they reported to Inspector #621 that an email notification was to be sent to them when there was a significant weight change documented into Gold Care. However, the RD reported that they had not received email notification of resident #001's identified weight change on or after a specific date in late spring 2017, and that they were not aware of the weight change until they reviewed resident #001's weight record during their scheduled visit to the home 15 days later. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents that had a weight change of five per cent body weight, or more, over one month, a change of seven and one-half per cent body weight, or more over three months, or a change of ten per cent of body weight, or more, over six months, are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated, to be implemented voluntarily.

WN #4: 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 a resident was taking 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.

During a record review by Inspector #196, resident #001 was identified as having been prescribed and receiving a particular class of medication. The physician's orders dated in 2017, included a specific medication to be given at bed time which was ordered and identified that registered staff were to assess effectiveness in two weeks time.

During the inspection, resident #001 reported to Inspector #196 that they had been having symptoms from a new medication that they had started the previous week. They also reported that the physician would be informed and see if it was needed as it was causing them to have symptoms.

The progress notes indicated that on a specific date, resident #001 exhibited a certain behaviour during the night shift. There were no other progress notes to indicate the residents response or effectiveness of the medication, from the starting date of the specific type of medication through to the date it was discontinued in 2017.

During the inspection, RPN #107 reported to the Inspector that this resident had been started on a specific type of medication at bedtime but it made them have symptoms. They also reported the medication was discontinued and the resident had less symptoms now.

An interview was conducted with the Administrator/DOC who confirmed to Inspector #196, that staff members were to document in the progress notes the resident's response to the medication and this had not been done. [s. 134. (a)]

2. During the inspection, Inspector #196 reviewed the health care records for resident #004, as they had required further inspection regarding an increase in frequency or intensity of pain based upon the MDS assessment. The MDS assessment protocol as found in the Gold Care program was reviewed and identified:
- on a particular date in 2017 - the MDS assessment - identified pain
- approximately six weeks previous - the MDS assessment - identified pain.

The physician's orders as identified in resident #004's chart included orders for analgesia. Specifically:
- on a date in 2017 - a specific analgesic medication to be given as needed for pain;
- on an earlier date in 2017 - a different analgesic medication to be given as needed for pain; and
- on a subsequent earlier date in 2017 - a regular scheduled analgesic medication to be given.

The Medication Administration Record (MAR) for resident #004 for a specific month in 2017, was reviewed for the administration of prn (as needed) analgesia. The review of the MAR revealed the following:
- a specific analgesic which was initialed on the MAR as administered on three particular dates in this specific month in 2017, and;
- on the back side of the MAR sheet: on one of these dates, there were no results or response to the analgesia noted; and
- on another one of these dates, there were no results or response to the analgesia noted; and
- on another one of these dates, there were no results or response to the analgesia noted.
- another medication was initialed on the MAR as administered two times on one date, and once on four separate dates in 2017; and
- on the back side of the MAR sheet; there were no results or response to the analgesia

noted for the two times it was given on the one date; and
- on the four separate dates, there were no results or response to the analgesia noted.

During the inspection, Inspector #196 conducted an interview with Administrator/DOC who reported that registered staff were to document the effectiveness of the "as needed" analgesia on the back of the MAR sheets. They confirmed to the Inspector that this had not been done for resident #004's specific medications that had been administered. [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 that ensures 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

During the inspection, Inspector #196 reviewed the licensee's medication incident reports which included the following:
- A report which identified that resident #005 had been administered another resident's medications;
- A report which identified that resident #005 had been administered their scheduled medication at the incorrect time;
- A report which identified that resident #006 had been administered an extra dose of medication;

- A report which identified that resident #007 had been administered their medication at the incorrect time.

The licensee's policy titled "Incident Reporting Procedure - BA-V-130-2" effective September 30, 2014, was reviewed by Inspector #196 for information. It was identified that policy did not clearly identify the notification of the physician, the resident, the resident's substitute decision-maker or the pharmacy service provider.

On a date during the inspection, Inspector #196 conducted an interview with the Administrator/DOC, who confirmed to the Inspector:
- the pharmacy service provider had not been informed of any of these four medication incidents that had occurred in the home and would only have been notified if it was a processing or blister pack error, not if it had been a clinical error;
- the physician had not been notified of the incident involving resident #005;
- the physician had not been notified of the incidents involving residents #006 and #007;
- the substitute decision maker was not notified of the two incidents involving resident #005;
- the substitute decision maker was not notified of the incident involving resident #007;
- there was no documentation to support that resident #006 had been notified of the medication error that had occurred.

The Administrator/DOC further confirmed to the Inspector that the medication incident reports were documented online and not all areas had been completed and should have been. In addition, they reported that the pharmacy service provider was not normally notified of medication incidents that had occurred in the home, except for those involving dispensing errors. [s. 135. (1)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review were implemented; and a written record was kept of everything provided for in clauses (a) and (b).

During a record review, Inspector #196 was unable to identify any written record indicating that a quarterly review of all medication incidents and adverse drug reactions had been conducted by the licensee.

During an interview with the Administrator/DOC, they reported to Inspector #196 that a quarterly review of all medication incidents and adverse drug reactions which had occurred in the home since the time of the last review, had not been undertaken. In addition, they reported that the pharmacy service provider had not been notified of medication incidents that had occurred in the home, except for those involving dispensing errors.

During an interview with Pharmacist #110, they reported to Inspector #196 that they, the pharmacy service provider, were not notified of medication incidents that were clinical but were notified of dispensing or packaging errors. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee has failed to ensure, that the following charges that were prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: 2. for goods and services

paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario, was not charged to residents.

During the medication observation on a date during the inspection, Inspector #196 identified that government stock drugs were dispensed from the pharmacy service provider into blister packs.

During the inspection, Inspector #196 conducted an interview with the Administrator/Director of Care. They reported that drugs had not been obtained from the Ministry of Health and Long-Term Care Ontario Drug Benefit Program (ODB) as the home was small and there was no need for a large supply. In addition, they reported that the pharmacy service provider did not charge residents for these medications that were available through ODB, except for one specific item.

Inspector #196 received copies of the licensee's, (Riverside Health Care Facilities Incorporated), invoices for the residents of the Rainy River Health Centre, dated October 2, 2017, for a particular month in 2017, from financial staff #112. Included with the invoices, were the till receipts from the pharmacy service provider for medications that had been dispensed and billed to several resident's of the home.

Inspector #196 conducted a telephone interview with Pharmacist #110 from the pharmacy service provider. They provided a spreadsheet titled “Nursing Charges” that identified the fill date, the charges, drug name and resident names for a particular month in 2017. The Inspector and the Pharmacist reviewed each resident on the spreadsheet and the subsequent pharmacy charges for the particular month in 2017. In addition, the Pharmacist and the Inspector consulted the "Requisition for ODB Approved Non-Prescription Drugs - 3060-97E (2017/04)" and "Pharmacy Requisition for Ontario Drug Benefit Approved Non-Prescription Drugs (ANPDs) - 4483-97E (2017/05)" as reference to the drugs provided by the Government of Ontario. Specifically:

- resident #007 was billed by the pharmacy service provider for five blister packs of a specific medication which totalled a specific dollar amount. Pharmacist #110 confirmed to Inspector #196 that this resident had been billed for a Government of Ontario stock drug. Inspector #196 then reviewed the invoices provided by financial staff #112 and identified that a specific dollar amount had been charged and debited from resident #007's account by Riverside Health Care Facilities Incorporated.

- resident #006 was billed by the pharmacy service provider for one blister pack of a specific medication, five blister packs of another medication and one bottle of another medication. Pharmacist #110 confirmed to Inspector #196 that this resident had been billed for Government of Ontario stock drugs. Inspector #196 then reviewed the invoices provided by financial staff #112 and identified that a specific dollar amount had been charged and debited from resident #006's account by Riverside Health Care Facilities Incorporated.

- resident #009 was billed by the pharmacy service provider for five blister packs of a specific medication, a container of another medication, five blister packs of another medication, and a bottle of another medication. Pharmacist #110 confirmed to Inspector #196 that this resident had been billed for Government of Ontario stock drugs. Inspector #196 then reviewed the invoices provided by financial staff #112 and identified that a specific dollar amount had been charged and debited from resident #009's account by Riverside Health Care Facilities Incorporated.

- resident #010 was billed by the pharmacy service provider for five blister packs of a specific medication, for five blister packs of another medication, and for five blister packs of another medication. Pharmacist #110 confirmed to Inspector #196 that this resident had been billed for Government of Ontario stock drugs. Inspector #196 then reviewed the invoices provided by financial staff #112 and identified that a specific dollar amount had been charged and debited from resident #010's account by Riverside Health Care Facilities Incorporated.

- resident #003 was billed by the pharmacy service provider for five blister packs of a specific medication, for five blister packs of another medication, and for a bottle of medication . Pharmacist #110 confirmed to Inspector #196 that this resident had been billed for Government of Ontario stock drugs. Inspector #196 then reviewed the invoices provided by financial staff #112 and identified that a specific dollar amount had been charged and debited from resident #003's account by Riverside Health Care Facilities Incorporated.

- resident #011 was billed by the pharmacy service provider for one bottle of medication. Pharmacist #110 confirmed to Inspector #196 that this resident had been billed for Government of Ontario stock drugs. Inspector #196 then reviewed the invoices provided by financial staff #112 and identified that a specific dollar amount had been charged and debited from resident #011's account by Riverside Health Care Facilities Incorporated.

- resident #002 was billed by the pharmacy service provider for five blister packs of a specific medications, and for five blister packs of another medication. Pharmacist #110 confirmed to Inspector #196 that this resident had been billed for Government of Ontario stock drugs. Inspector #196 then reviewed the invoices provided by financial staff #112 and identified that a specific dollar amount had been charged and debited from resident #002's account by Riverside Health Care Facilities Incorporated.

A further telephone interview was conducted on a specific date in October 2017, with Pharmacist #110 who reported to Inspector #196 that drugs that had been billed to residents included a dispensing fee. In addition, they reported that the pharmacy owner had now received a Government of Ontario list and a provider number and would be placing an order in the near future with ODB.

A further telephone interview was conducted on a specific date in October 2017, with the Administrator/Director of Care who reported to the Inspector that, they were unaware that residents in the long-term care unit of the Rainy River Health Centre had been charged for Government of Ontario stock drugs that were available under the Ontario Drug Benefit Program of the Government of Ontario. Email correspondence between the Administrator/Director of Care and the pharmacy owner of the pharmacy service provider, revealed that the owner and the pharmacist, were unaware of the process of obtaining ODB drug stock until the Inspector had contacted the pharmacist the previous week. [s. 245. 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 the following charges that are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: 2. for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario, is not charged to residents, to be implemented voluntarily.

WN #7: 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.

During the inspection, Inspector #621 observed several cracks in the enamel around the drain of the bathroom sink in a particular resident room.

During an interview, resident #002 reported to Inspector #621 that the cracks in their bathroom sink had been there since they had moved into the home.

During an interview with PSW #103, they reported to Inspector #621 that they were aware of the cracks located in the bathroom sink in a particular resident room, that the cracks had been there for more than a year, and that home's staff were to complete a maintenance requisition on any damage found in the home in order for maintenance staff to follow up. Additionally, PSW #103 reported that they had not completed a maintenance requisition to address the cracked sink in resident #002's bathroom, and that there was not a process that they were aware of to determine whether a maintenance requisition had been completed by another staff person for the same issue.

On a specific date during the inspection, the Administrator/DOC observed resident #002's bathroom sink and confirmed that it was in disrepair at the time of the inspection.

During an interview with the Administrator/DOC, they reported to Inspector #621 that it was their expectation that home's staff completed a maintenance requisition for any damage found in the home, and forward the completed requisition to the maintenance staff's dedicated mailbox. The Administrator/DOC indicated that it was their expectation that the maintenance staff person checked their mailbox on each shift and followed up on the completed requisition immediately.

Further, the Administrator/DOC identified that if the issue required additional time or resources that the maintenance staff person was expected to inform the Administrator/DOC and the Director of Environmental Services for further direction. When the Inspector inquired whether a maintenance requisition had been completed by home's staff for resident #002's bathroom sink, the Administrator/DOC reported that the home did not have a process to track maintenance requests and their completion. [s. 15. (2) (c)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that Family Council, if any, and in any case was consulted with at least every three months.

During an interview with Family Council President #113, they reported to Inspector #621 that the home's management had not consulted with Family Council at least every three months over the previous year.

Inspector #621 reviewed copies of the Family Council meeting minutes over the previous 12 months, which documented that the most recent meeting of Family Council meeting occurred in January 2017, with the Administrator/DOC present.

During an interview on a specific date in October 2017, the Administrator/DOC confirmed to Inspector #621 that there had not been a meeting of Family Council since January 2017, and that they had not consulted with Family Council at least every three months, as per legislative requirements. [s. 67.]

WN #9: 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 has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were communicated, in a manner that complies with any requirements that may be provided for in the regulations, to residents who cannot read the information.

During a tour of the home on a dated during the inspection, Inspector #621 identified that inspection reports #2015_339617_0021 and #2016_435621_0014 from the past two years were not posted in the home, in a location accessible to all residents.

During an interview, the Administrator/DOC confirmed to Inspector #621 that the home had a copy of its inspection reports from the past two years, but that they were not posted in the home at the time of the inspection, where posting of other required information was kept easily accessible to residents. [s. 79. (3) (k)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 120. Responsibilities of pharmacy service provider
Every licensee of a long-term care home shall ensure that the pharmacy service provider participates in the following activities:
1. For each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.
2. Evaluation of therapeutic outcomes of drugs for residents.
3. Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.
4. Developing audit protocols for the pharmacy service provider to evaluate the medication management system.
5. Educational support to the staff of the home in relation to drugs.
6. Drug destruction and disposal under clause 136 (3) (a) if required by the licensee's policy. O. Reg. 79/10, s. 120.

Findings/Faits saillants :

1. The licensee has failed to ensure that the pharmacy service provider participated in the following activities: Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.

During the inspection, Inspector #196 reviewed the licensee's medication incident reports for those incidents which had occurred in the previous six months.

During an interview with Administrator/DOC on a date during the inspection, they reported to Inspector #196 that the pharmacy service provider did not review medications incidents that had occurred in the home.

On another date, during an interview with Pharmacist #110, from the pharmacy service provider, they confirmed to Inspector #196 that they did not review medication incidents that involved residents of the long-term care home. [s. 120. 3.]

Issued on this 11th day of December, 2017

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

Original report signed by the inspector.