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 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
Nov 22, 2018	2018_633577_0016	025584-18	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

DEBBIE WARPULA (577), MELISSA HAMILTON (693)

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 22-26, 2018.

An additional intake was completed during this inspection:

- One Critical Incident (CI), related to a resident fall with injury.

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 of Care, Registered Nurse (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Manager of Corporate Food Services, residents and family members.

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

During the course of this inspection, Non-Compliances were issued.
- **8 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. 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.

During a staff interview, resident #006 had been identified as having had on-going altered skin integrity to a particular area.

A review of the physician progress notes identified that resident #006 had developed altered skin integrity and was being treated with a specific treatment.

A review of the Medication Administration Record (MAR) for three particular months, indicated daily treatments initially and treatments were changed to every second day for two other months.

A review of the 'Impairment of Skin Integrity Assessment and Treatment Record' identified that the altered skin integrity assessment and treatments were initiated on a particular day. A further record review of the Impairment of Skin Integrity Assessment and Treatment Record revealed inconsistencies in assessments, as follows:

-for a particular month, there were no assessments for 15 days;

-for another month, there were no assessments for 18 days; and
-for another month, there were no assessments for 13 days.

A review of the home's "Skin and Wound Program" with no revision date, indicated that staff were required to assess all wounds on the residents first bath day of week, completing the Wound Care Flow Sheet/Treatment record form (Impairment of Skin Integrity Assessment and Treatment Record).

During an interview with RPN #101, they reported to Inspector #577 that resident #006 currently had altered skin integrity to a particular area and staff were required to document on the "Impairment of Skin Integrity Assessment and Treatment Record" with every treatment and this was considered their clinical tool.

During an interview with RPN #105, they reported that resident #006 had altered skin integrity and required a particular treatment every second day. They further reported that staff were required to document assessments on the 'Impairment of Skin Integrity Assessment and Treatment Record" once weekly.

During an interview with the Manager of Care, they reported to Inspector #577 that staff were required to document assessments on the "Impairment of Skin Integrity Assessment and Treatment Record" once weekly and confirmed there were inconsistencies with the assessments over four different months. [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 to ensure 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 #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 an interview with resident #003 on a particular day, they reported that they had pain to a specific area, rated their pain as 10/10 and had been waiting for their pain medication to be sent from the pharmacy.

During a record review of resident #003's MAR and the physician orders, Inspector #577 identified that the resident had been receiving a scheduled pain medication three times daily (tid) and two other pain medications every four hours (hrs) as needed (prn), up until a particular day. Then a new physician's order was initiated for pain medication every four hrs prn, and scheduled pain medication tid and twice daily (bid).

A review of the physician notes dated a particular day indicated that the resident had an accident and had complained of pain to a specific area; xrays were ordered and their pain medication was changed.

A review of the physician medication orders dated for a specific day, indicated that the new pain medication was ordered at 1020 hrs. A review of the MAR for that day in indicated that resident #003 was administered their scheduled medication at 0900 hrs, and the new pain medications were not given until 1600 hrs.

A record review of the most recent pain assessment was documented which identified that resident #003 had pain to specific areas and was taking regular scheduled and prn medication; their pain score was documented as a zero.

A review of the home's policy "Pain Management Program – ORG-II-RES-05.1" revised April 11, 2018, indicated that the pain assessment which utilized the electronic Pain

Assessment Tool was to be completed on admission, quarterly, when a resident had a change in condition, when a resident stated they were in pain or observed to be in pain.

In an interview with RPN #101, they reported to Inspector #577 that staff were required to document a pain assessment on the electronic pain tool when there had been a change in pain; further, when there had been new medication ordered and pharmacy hadn't delivered it, they were expected to have obtained the medication from the acute care side.

In an interview with RN #104, they reported that the pain assessments were done quarterly and with a change in the resident's condition.

During an interview with RPN #102, they reported that they had obtained pain medication from the acute care side on that particular day, at 1600 hrs, as the outside pharmacy provider delivers medication at 1700 hrs; and further confirmed that the day shift staff should have obtained the medication when it was ordered.

During an interview with the Manager of Care, they reported that staff were required to document a pain assessment on the electronic pain tool on admission, quarterly and with a change in condition. They confirmed that the most recent electronic pain tool was completed and reported that it should have been re-done on that particular day with the resident's increase in pain and change in pain medication. They further confirmed that when new medication has been ordered and had not been received from the outside pharmacy, staff were expected to obtain the medication from the acute care side. [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 to 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, to be implemented voluntarily.

WN #3: 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 an interview with resident #003 on the afternoon of a particular day, they reported that they had pain to a specific area.

Inspector #577 reviewed the MAR over a two month period, and found that the resident received prn medication for pain on 30 occasions. A review of the 'response notes' on the MAR and the progress notes identified that the response of effectiveness to the medication was documented on 19 occasions, or 63 percent (%).

A review of the home's policy entitled "Pain Management Program - #ORG-II-RES-05.1" last revised April 11, 2018, identified that when PRN (as needed) medications were administered, residents were assessed to determine medication effectiveness and that the effects of the medication were documented on the 'Pain Monitoring Flow Sheet', or on the back of the MARS, and could also be documented in the electronic medical record.

In an interview with RPN #101, they reported to the Inspector that resident #003 had complained of pain to a specific area and was prescribed regularly scheduled pain medication and prn medication. They further reported that staff document the response to pain medication on the MAR and progress notes. Inspector #577 and RPN #101 reviewed together the MAR and they confirmed that the follow up documentation for prn medication was inconsistent.

During an interview with RN #104, they reported to the Inspector that a response to a prn medication should be documented on the MAR and progress note.

During an interview with the Manager of Care, Inspector #577 reviewed the back of the MAR for a two month period. They confirmed that the follow up documentation was inconsistent and staff were required to document the effectiveness of prn pain medication on the back of the MAR to determine the effectiveness. [s. 134. (a)]

2. Resident #004 was identified as having increased pain from their most recent Minimum Data Set (MDS) assessment.

During an interview with resident #004, they reported to Inspector #577 that they experienced pain to specific areas and they rated their pain as a 7/10.

A review of the physician orders indicated that the resident was prescribed a specific pain medication every four hrs prn.

Inspector #577 reviewed the MAR over two specific months, and found that the resident received prn medication for pain on 24 occasions. A review of the 'response notes' on the MAR and the progress notes identified that the response of effectiveness to the medication was documented on 11 occasions, or 45 per cent (%).

A review of the home's policy entitled "Pain Management Program - #ORG-II-RES-05.1" last revised April 11, 2018, identified that when PRN (as needed) medications were administered, residents were assessed to determine medication effectiveness and that the effects of the medication were documented on the 'Pain Monitoring Flow Sheet', or on the back of the MAR, and could also be documented in the electronic medical record.

In an interview with RPN #101, they reported to Inspector #577 that resident #004 had complained of pain to specific areas and received pain medication every four hrs prn. They further reported that staff document the response to pain medication on the MARS

and progress notes. Inspector #577 and RPN #101 reviewed together the MAR and they confirmed that the follow up documentation for prn medication was inconsistent.

In an interview with RPN #105, they reported that resident #004 had complained of pain to specific areas and received medication for their pain. They further reported that staff document the response to pain medication on the MAR and progress notes.

During an interview with the Manager of Care, Inspector #577 reviewed the back of the MAR for two specific months. They confirmed that the follow up documentation was inconsistent and staff were required to document the effectiveness of prn pain medication on the back of the MAR to determine the effectiveness. [s. 134. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when 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 #4: 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. (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 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 changed or care set out in the plan was no longer necessary.

Resident #003 was observed on three days to have an intervention in place on their bed.

A review of resident #003's most current care plan, did not identify that resident #003 utilized any interventions while in their bed.

In an interview with RPN #102, they indicated that resident #003 utilized the intervention on their bed as a Personal Assistive Safety Device (PASD) for bed mobility. Together with Inspector #693, RPN #102 reviewed resident #003's most current care plan and stated that the intervention for resident #003 was not identified on their care plan and should have been updated to reflect resident #003's current care needs.

A review of the home's policy: "Riverside Health Care Facilities: Personal Assistance Services Devices Policy" last revised in August 2013, identified that the procedure for registered staff to ensure the proper use of PASDs included the development of a care plan related to a specific activity of living for which the PASD is required, listing when it is to be used, for how long, frequency of monitoring and the specific risks associated with the use as well as to have documented and revised the care plan as necessary.

In an interview with the Manager of Care, they stated that resident #003 utilized the intervention on their bed and was considered PASDs for bed mobility and call bell access. They reviewed resident #003's most current care plan and indicated that resident #003's care plan did not include the use of the intervention and the care plan should have been updated to reflect resident #003's current care needs. [s. 6. (10) (b)]

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 respond in writing within ten days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council meeting minutes dated March 13, 2018, identified dietary concerns, requests and comments including food quality and palatability, dining experience and menu suggestions.

During an interview with the Assistant to the Resident Council #105, they reported that following the meeting, the Administrative Assistant would have typed the minutes and would be given to the Manager of Care. They further reported that there was not a written response given to the Resident Council for the meeting on March 13, 2018.

During an interview with the Manager of Care, they confirmed that neither they nor the Manager of Food Services had responded in writing within 10 days to the Resident Council for the March 2018, meeting. [s. 57. (2)]

WN #6: 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 the Resident Council was consulted with at least every three months.

During an interview with the Assistant to the Resident Council #105, they reported to Inspector #577 that they did not recall whether the Manager of Care had consulted with the Resident Council within the past year.

During an interview with the Resident Council President #005, they reported to Inspector #577 that they could recall the Manager of Care being present for one of the Council meetings.

During an interview with the Manager of Care, they reported to Inspector #577 that they had not consulted with the Resident Council at least every three months; they further reported that they had met with the Resident Council on one occasion over the past three to five years. [s. 67.]

WN #7: 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, subject to compliance with subsection 71(6), the review of meal and snack times.

During an interview with the Resident Council President #005, they reported to Inspector #577 that they could not recall whether the Residents' Council had reviewed meal and snack times during their meetings.

A record review of the last three Resident Council meeting minutes, from March-September 2018, had not included a review of meal and snack times.

During an interview with the Manager of Corporate Food Services #107, they reported to Inspector #577 that they had never reviewed meal and snack times with the Residents' Council. [s. 73. (1) 2.]

WN #8: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of the home's medication incidents from the last quarter, identified an incident involving resident #007 in which a medication tablet was found on the floor in their bathroom by a Personal Support Worker (PSW) on a day in July 2018. The medication incident report indicated that the nursing staff were unable to identify when this medication was missed as it was to be given three times daily. The incident was reviewed by the Manager of Care, who had indicated that the medication was found on the floor and therefore had been missed, and staff were to ensure all medications were given as ordered.

A review of resident #007's MAR and physician's orders from July 2018, indicated that the particular medication was ordered to be administered three times daily. The MAR was signed by registered nursing staff, three times daily indicating that resident #007 had received the medication as ordered.

In an interview with RPN# 101, they stated that if a medication was found on the floor in a resident's washroom it would be a medication incident and would indicate that the medication was not administered as ordered. RPN# 101 stated that the home's process for medication administration was to sign the MAR before the medications were administered to the resident.

A review of the home's policy "Riverside Health Care Facilities: Medication Administration" revised December 2014, identified that the procedure for registered staff administering medication was to sign for the administration of medications after the resident had taken the medication.

In an interview with the Manager of Care, they stated that the home's procedure for registered staff required them to sign the MAR after the resident had received the medication. They further indicated that resident #007's medication was not given as directed by the prescriber on a date that cannot be specified as the MAR had been signed which indicated that the medication was given. [s. 131. (2)]

Issued on this 23rd day of November, 2018

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

Original report signed by the inspector.