Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 19, 2019	2019_740621_0028	014859-19	Critical Incident System

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

JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 11 - 12, 2019.

The following Critical Incident System (CIS) intake was inspected during this CIS Inspection:
- One intake related to a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), a Registered Nurse (RN), a Registered Practical Nurse (RPN), a Personal Support Worker (PSW), the Registered Dietitian (RD), the Food Services Manager (FSM) and the Physical Therapy Assistant (PTA).

The Inspector also reviewed the home's supporting documentation, including relevant health care records, specific licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **3 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 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was received by the Director on a day in July 2019, regarding a fall with injury of resident #001.

During an interview with RN #100, they reported that resident #001 had been identified at a certain risk level for falls; and that between two specific dates in the summer of 2019, the resident had been refusing a certain care activity, resulting in a negative outcome.

Inspector #621 reviewed resident #001's healthcare record, including their most current plan of care with a specified focus, at the time of the fall, which identified the following:

- On a specific date in June 2019, the home's RD completed an assessment of resident #001, which identified that resident #001 was a certain risk level, with a specific medical condition and corresponding outcome. The RD assessed the resident to require a particular form of nutrition therapy, prescribed at specified intervals;
- On the same day in June 2019, the home's RD made an entry in a specific location of the resident's healthcare record, which identified the resident required a specific form of nutrition therapy for a specified condition. It was noted that no further changes to the healthcare record, for the identified nutrition therapy, were made thereafter; and

- The Medication Administration Record (MAR) in July, 2019, identified an entry for the prescribed nutrition therapy, which was hand written into the MAR. No information the amount of the specified nutrition therapy, or administration times were identified on the MAR entry. However, it was noted that registered staff were documenting that the prescribed nutrition therapy was being administered daily at specified intervals.

During an interview with the home's RD, they reported to the Inspector that they had completed an assessment of resident #001 on a particular day in June 2019, and at that time, they assessed the resident to require a specific form nutrition therapy. The RD identified that they documented the resident was to be provided the identified nutrition therapy in both their assessment report, and as an entry in the physician orders section of the resident's chart on the same date. The RD confirmed that they had not provided details regarding the expected amount or administration times of the nutrition therapy. Consequently, the RD identified that, due to this oversight, resident #001's nutrition care plan provided unclear direction with respect to specific amounts and times required for the prescribed nutrition therapy.

During an interview with the DOC, they reported to the Inspector that it was their expectation that, order entries made for specific nutrition therapies, whether by the RD or physician, included details including required amounts and times of administration. The DOC identified that if an order was unclear, that registered staff should have also clarified the order with the RD before processing onto the MAR. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of care as set out in the plan of care was documented for resident #001.

A Critical Incident System (CIS) report was received by the Director on a day in July 2019, regarding a fall with injury of resident #001.

During an interview with RN #100, they reported that resident #001 had been identified at a certain risk level for falls; and that between two specific dates in the summer of 2019, the resident had been refusing a certain care activity, resulting in a negative outcome.

Inspector #621 reviewed resident #001's healthcare record, including their most current plan of care with a specified focus, at the time of the fall, which identified the following:

- On a specific date in June 2019, the home's RD completed an assessment of resident #001, which identified that resident #001 was a certain risk level, with a specific medical

condition and corresponding outcome. The RD assessed the resident to require a particular form of nutrition therapy, prescribed at specified intervals;
- On the same day in June 2019, the home's RD made an entry in a specific location of the resident's healthcare record, which identified the resident required a specific form of nutrition therapy for a specified condition. It was noted that no further changes to the healthcare record, for the identified nutrition therapy, were made thereafter; and
- The Medication Administration Record (MAR) in July, 2019, identified an entry for the prescribed nutrition therapy, which was hand written into the MAR. No information the amount of the specified nutrition therapy, or administration times were identified on the MAR entry. However, it was noted that registered staff were documenting that the prescribed nutrition therapy was being administered daily at specified intervals.

On further review of the July 2019 MAR, Inspector #621 noted missing documentation with regards to the administration of the prescribed nutrition therapy over multiple dates and times.

During an interview with the DOC, they reported to the Inspector that it was their expectation the MAR, which was a part of the resident's plan of care, was completed in full, with no missing documentation on the record. The DOC reviewed resident's July 2019, MAR with Inspector #621 and confirmed that there was missing documentation for the prescribed nutrition therapy, for the identified dates and times. [s. 6.(9) 1.]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; and to ensure that the provision of care as set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was complied with in respect to each of the organized programs required under section 8 to 16 of the Act, and each of the interdisciplinary programs required under section 48 of Ontario Regulation 79/10: 3. The Falls Prevention Program, as well as the Nutrition and Hydration Program were evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A Critical Incident System (CIS) report was received by the Director on a day in July 2019, regarding a fall with injury of resident #001.

During an interview with RN #100, they reported that resident #001 had been identified at a certain risk level for falls; and that between two specific dates in the summer of 2019, the resident had been refusing a certain care activity, resulting in a negative outcome.

On review of the home's policies titled "Falls Prevention Program Policy, DEP-NUR-GEN-F-5" and "Nutrition and Hydration Program, ORG-II-RES-10.2", as provided by the Director of Care (DOC) on a date in September 2019, it was noted by Inspector #621 that both program policies were outdated, with "Effective Dates" of January 31, 2017 and April 18, 2018, respectively.

During an interview with the DOC, they informed the Inspector that although they were considering the implementation of Extendicare policies in the home, at the time of inspection, the home continued to utilize organizational policies developed and implemented through the licensee. The DOC reviewed the Falls and Nutrition Program policies and confirmed that they were more than a year old. Further, the DOC stated that it was their expectation that the home's required program, policies and procedures were reviewed and updated at least annually. [s. 30. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following is complied with in respect to each of the organized programs required under section 8 to 16 of the Act, and each of the interdisciplinary programs required under section 48 of Ontario Regulation 79/10: 3. The Fall Prevention Program and the Nutrition and Hydration Program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, with prevailing practices, 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 resident with the following weight changes were assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated: 4. Any other weight change that compromises the resident's health status.

A Critical Incident System (CIS) report was received by the Director on a day in July 2019, regarding a fall with injury of resident #001.

During an interview with RN #100, they reported that resident #001 had been identified at a certain risk level for falls; and that between two specific dates in the summer of 2019, the resident had been refusing a certain care activity, resulting in a negative outcome.

Inspector #621 reviewed resident #001's electronic record, which identified a significant weight change between specified dates in June and July 2019.

The Inspector reviewed documentation from the home's Registered Dietitian (RD), which identified that the first and only assessment completed by them for the resident, occurred on a specific date in June 2019. Further review, found no RD referrals throughout the electronic or paper health care record for the duration of the resident's admission.

During an interview with Registered Dietitian #103, they reported to the Inspector that they had completed an assessment of resident #001 on the specified date in June 2019, but had not received referral notification from the registered staff of the home, to alert them of a significant weight change that was documented on the residents electronic health record on or after a specific date in July 2019. The RD reported that resident #001 had been refusing a particular care activity, and was assessed by them to be high nutrition risk. The RD also confirmed that the resident's weight change between specific dates in June and July 2019, was significant. The RD further reported that they visited the home only a certain number of days a month, and in order to stay on top of nutrition care issues, the home's nursing staff should have made a referral to them in Point Click Care (PCC) when the significant change occurred, but did not.

During an interview with PSW #101, they reported that PSW staff were responsible for weighing residents during the first week of every month, using a specific type of scale. PSW #101 identified that they recorded the measured weights on a certain document, and RPN staff were then required to transcribe the weights into PCC. Additionally, they identified, that if there was a significant weight change, the RPN would be alerted on PCC when they entered the weight, and would be responsible for creating a referral in PCC to the Registered Dietitian.

During an interview with the DOC, they confirmed that RPNs were responsible for ensuring a referral was sent to the RD for any significant weight change documented, and that a referral had not been sent to the RD for resident #001's significant weight change, on or after a particular date in July 2019. The DOC reported that there were potential gaps in knowledge about the process for submitting RD referrals, and confirmed that there had been a lack of interdisciplinary team approach taken with regards to resident #001's significant weight change. [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 to ensure that resident with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated: 4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

Issued on this 19th day of September, 2019

[redacted]

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

Original report signed by the inspector.