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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Aug 30, 2018	2018_536537_0022	014852-18	Resident Quality Inspection

Licensee/Titulaire de permis

Richmond Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

Long-Term Care Home/Foyer de soins de longue durée

Richmond Terrace
89 Rankin Avenue AMHERSTBURG ON N9V 1E7

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

NANCY SINCLAIR (537), CASSANDRA TAYLOR (725)

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): August 7, 8, 9, 10, 13, 14, 15, 16 and 17, 2018

The following complaint intakes were inspected concurrently within this RQI:
Log #001752-18/IL-55127-LO regarding plan of care and continence care.
Log #006201-18/IL-56240-LO regarding a bed refusal.
Log #004685-18/IL-55868-LO regarding wound care

The following intakes were inspected concurrently within the RQI regarding falls:
Log #008449-17/CIS 1149-000009-17
Log #024674-17/CIS 1149-000021-17
Log #012629-18/CIS 1149-000012-18
Log #008167-18/ CIS 1149-000011-18
Log #007723-18/CIS 1149-000009-18

The following intakes were completed concurrently within the home's RQI:
Log #022012-17/CIS 1149-000025-17 regarding a resident missing for less than 3 hours.
Log #015814-18/CIS 1149-000016-18 regarding failure of the air conditioning.
Log #015365-18/CIS 1149-000014-18 regarding alleged resident to resident abuse

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Clinical Services (DCS), Director of Environmental Services (DES), Rehabilitation Coordinator (RC), Registered Dietitian (RD), Recreation Aide (RA), two Registered Nurses (RN), nine Registered Practical Nurses (RPN), ten Personal Support Workers (PSW), a Housekeeping Aide (HA), Resident Council Representative, Family Council Representative, Residents and Families.

The inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, meal service, medication passes, medication storage areas, reviewed health care records and plans of care for identified residents, policies and procedures of the home, minutes from meetings and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **5 WN(s)**
- **5 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 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 has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

a) During stage I of the Resident Quality Inspection (RQI), a resident was observed in their wheelchair in a specific position.

PSW #111 stated that the resident used the specific position on their wheelchair for a specified reason. When asked by Inspector #725 where that information would be documented, PSW #111 responded that it would be in Point of Care(POC) and they would have a logo on the back of their chair to indicate the use of the specific positioning.

PSW #112 stated that the resident did not use the specified positioning on their wheelchair. When asked by Inspector #725 where that information would be documented, PSW #112 stated that the information would be located in the resident's care plan.

An observation was made of the resident's wheelchair and there was no logo on the back of the chair as indicated by PSW #111.

A record review was completed of the plan of care. There was no documentation relating to the specific positioning for this resident in their wheelchair.

Rehabilitation Coordinator #110 stated that information relating to specific positioning of a resident in a wheelchair should be documented in the residents' plan of care.

Rehabilitation Coordinator #110 reviewed the resident's plan of care with inspector #725 and confirmed that there was no documentation relating to the specific positioning in the wheelchair and should have been noted in the written plan of care.

b) During Stage I of the Resident Quality Inspection (RQI), a resident was observed in their wheelchair in a specific position.

Personal Support Worker (PSW) #107 stated that the resident used the specific positioning in their wheelchair regularly for identified specific reasons. PSW #107 shared also that they were unsure if the specific positioning would be included in the resident's plan of care. PSW #107 shared they used the specific positioning for the resident in their wheelchair because they knew the resident and the reasons why the specific positioning was required.

Registered Nurse (RN) #108 stated that when a resident used specific positioning in a wheelchair, there was an assessment located on the computer. RN #108 stated that the use of the specific positioning in the wheelchair should be included in the written plan of care and the reason for its use. RN #108 reviewed the current written plan of care for the resident and stated that it did not include the use of the specific positioning in the wheelchair at all.

Rehabilitation Coordinator #110 stated that they completed assessments for all residents related to the use of the positioning in their wheelchairs, and would then include the specific positioning and its use in the written plan of care. Rehabilitation Coordinator #110 reviewed the current written plan of care for the resident and stated that it did not include the positioning for the resident and that they would complete the required documentation in the written plan.

Director of Clinical Services #118 stated that it was the expectation that when a resident was assessed for specific positioning in their wheelchair for any reason, that there should be documentation of the use of the specific positioning in the written plan of care.

The licensee has failed to ensure that the planned care for the use of the specific positioning in their wheelchair for resident #001 and #005 was included in the written plan of care. (537)' [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided

to the resident as specified in the plan.

a) During a lunch observation, a resident was observed in a position other than upright while being fed. Inspector #725 spoke with PSW #119 and asked what the safe position would be for a resident when eating. PSW #119 stated upright. Inspector #725 asked if the resident was in the proper position. PSW #119 stated the position was to assist the resident with eating.

A record review was completed for the resident which stated resident was to be at a 90 degree angle when eating as directed from the Speech Language Pathologist (SLP) report.

Inspector #725 spoke with the Director of Clinical Services #118 who confirmed residents should be at a 90 degree angle when eating.

Inspector #725 spoke with the Director of Culinary Services #120 who confirmed residents should be at a 90 degree angle unless otherwise assessed by the Registered Dietitian (RD).

Inspector #725 spoke with the Registered Dietitian (RD) #121. Inspector #725 asked what was considered safe positioning for residents while dining. RD #121 stated 90 degrees unless otherwise indicated. Inspector #725 asked who would complete the assessment and where would it be documented. RD #121 stated it would be a multidisciplinary assessment and it would be documented in the resident's plan of care.

Inspector #725 asked RD #121 what would be the safe position for the identified resident. RD #121 stated 90 degrees as care planned. Inspector #725 stated resident was observed in a position that was not 90 degrees and asked if this was safe positioning. RD #121 stated no, unless there was a change and stated no referral was received for this resident.

b) A Complaint log was submitted to the Ministry of Health and Long Term Care by a family member of a resident. The family member raised concerns of care not being provided to the resident for the management of a known medical issue.

A Resident was admitted to the home with a known history of a medical issue. Family member of the resident stated staff noted behaviours which often indicated the onset of the known medical issue, and as a result, the staff implemented assessments. From the

results of the assessment, the Nurse Practitioner (NP) at that time was contacted and provided treatment directions and for follow up from staff when assessments were completed.

NP completed a follow up visit at which time it was determined that the treatments as ordered had not been completed and further follow up was not able to be completed.

Point Click Care (PCC) documentation by the physician of the resident indicated that treatment directions as per the NP had not been completed The physician of the resident noted that there was not a significant improvement in the health status of the resident and ordered a different treatment directions.

Registered Nurse #108 stated that the treatment plan should have been communicated to all shifts for completion.

Executive Director #100 stated that care for the resident, specifically the completion of the treatment directions, had not been completed as specified in the plan.

The licensee has failed to ensure that the residents received care, as specified in the plans. (537) [s. 6. (7)]

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 written plan of care for each resident sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Executive Director #100 provided a copy of the home's sufficient staffing plan for the Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW). The plan indicated the following complement of RN, RPN and PSW staff for the building;

Days:
1 RN
3 RPNs on Monday, Wednesday, Friday, Saturday and Sunday
4 RPNs on Tuesday and Thursday
14 PSWs

The home's sufficient staffing plan stated the following: "All staff are to be replaced using the call-in procedures as per collective agreement. If RPN's call in, the usual call-in procedure will be completed as well as going into overtime. If no RPN is available, the call-in procedure will be completed with the RN roster. If we are two short, please see the

working short policy."

The home's Working Short Policy provided direction to registered staff when working short. The policy stated the following : "If the charge nurse is unable to work the scheduled shift, we will first attempt to fill the shift with an RN at regular time. If unable to replace the charge nurse at regular time and a Nurse Manager is in the building during the entire shift,the Nurse Manager will act as the charge nurse for the shift. If there is not a Nurse Manager in the building, we will attempt to fill the charge nurse by offering the RN's overtime. If unable to fill the RN shift with an RN, we will than attempt to replace the shift with an RPN; first at regular time and then if unsuccessful RPN's will be offered OT." The policy also stated "If a nurse manager is in the building they will complete all required treatments, re-admissions & transfers and call-ins. If there is not a nurse manager in the building the nurse will be required to complete all treatments on stageable wounds within their assigned rooms."

RPN # 115 stated that on occasion when working short staffed that treatments would get missed and that registered staff attempted to pass on to the next shift the uncompleted tasks to be completed. It was also stated by RN # 108 that staff attempted to complete all tasks and would report to the next shift what was left unfinished to attempt to finish on the next shift
Director of Clinical Services (DCS) #118 stated that the home attempted call ins to avoid working short, but if staff were working short the expectation would be whatever additional work was assigned, staff would complete it.

During record review for three identified residents, it was documented on multiple occasions that treatments were missed due to being short staffed. Review of the electronic treatment Administration Record (eTAR) confirmed that treatments were not completed.

On review of the staff schedule, the home was short staff per the expected complement on the specified dates of missed treatments.

Inspector #725 reviewed the records for the residents with the Director of Clinical Services (DCS) #118, who stated that care was missed and should have been completed for the residents. On review of the schedule , DCS # 118 stated that the home was working short on multiple occasions including the specified dates.

The licensee has failed to ensure that the staffing plan provided for a staffing mix that

was consistent with the assessed care and safety needs, specifically wound care, for three identified residents. [s. 31. (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 the staffing plan provided for a staffing mix that is consistent with residents' assessed care and safety needs, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Three residents were identified as having areas of altered skin integrity.

Registered Nurse (RN) #127 stated that if a resident had a wound, a weekly wound assessment would be completed and documented in Point Click Care (PCC).

The skin and wound assessments in PCC were reviewed for the identified residents. On multiple occasions the residents did not have wound assessments completed weekly.

Director of Clinical Services (DCS) #118 stated that residents should have a weekly wound assessment completed if they had an area of altered skin integrity.

Inspector #725 reviewed the wound care assessments of the three identified residents with DCS #118. DCS #118 stated the residents should have had a weekly wound assessment completed.

The licensee has failed to ensure three identified residents received a weekly wound assessment by a member of the registered nursing staff. [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 #4: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A resident was identified to have a medication order for a specific medication at a specific time.

During the record review of the medication incidents it was identified that a Registered Practical Nurse (RPN) reported that a resident had been administered another residents' medication.

Inspector #725 spoke with Executive Director #100 who confirmed the resident received medications that were not ordered for them and that it was a medication error.

The licensee has failed to ensure that no drug was administered to a resident unless the drug has been prescribed for the resident. [s. 131. (1)]

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

A Complaint was submitted to the Ministry of Health and Long Term Care on January 19, 2018, by a family member of a resident. The family member raised concerns of care not being provided to the resident for a known medical condition.

The Nurse Practitioner wrote an order for specific medications for the resident. Review of the electronic Medication Administration Record (eMAR) for the resident indicated they did not receive their medication as ordered.

Executive Director #100 stated that the home had provisions in place for the resident to have received their medication as ordered and they did not receive prescribed medications.

The licensee has failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident’s health.

A Complaint was submitted to the Ministry of Health and Long Term Care by a family member of a resident of not being provided care for a known medical issue.

The Nurse Practitioner wrote an order for the resident. Review of the electronic Medication Administration Record (eMAR) for the resident indicated the resident did not receive their medication as ordered.

The home's policy titled "Medication Incident Reporting - 9-1" last revised January 2018, stated in part: "Medication Incident is defined as: Any preventable event that may cause or lead to inappropriate mediation use or client harm while the medication is in the control of the health care professional, client or consumer." The goal is to stimulate reporting to capture all incidents for evaluation. Our objective is to focus on process improvement and reduction of future incidents with incident-prevention strategies to provide a safe medication management system. Procedure: Complete the Medical Pharmacies ‘Medication Incident Report’ online when a medication incident or adverse drug reaction has occurred including near miss situations."

Registered Nurse #108 stated that the missed doses of the ordered medication for the resident would be considered a medication incident and a medication incident report should have been initiated.

On August 15, 2018, Executive Director #100 stated that the missed doses of the ordered medication would be considered a medication incident, however, they were not able to find record of a medication incident at the home, nor was the pharmacy able to find evidence that a medication incident report had been initiated as a result of the missed doses.

The licensee has failed to ensure that a medication incident report was completed when the resident missed doses of a medication as prescribed. [s. 135. (1) (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 every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

Issued on this 31st day of August, 2018

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

Original report signed by the inspector.