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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 6, 2016	2016_435621_0014	028548-16	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

JULIE KUORIKOSKI (621), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 3, 4, 5, 6, 7, 2016.

During the course of the inspection, the inspector(s) spoke with the Nurse Manager, the Acting Nurse Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, President of Residents' Council, President of Family Council, family members and residents.

During the course of the inspection, the Inspector(s) completed observations of the resident's home area, observed staff to resident and resident to resident interactions, observed medication administration, reviewed infection control practices, reviewed the home's health care records for several residents, along with relevant policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 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. (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 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.

During the inspection, resident #003 was identified to have had a fall.

Inspector #621 reviewed resident #003's written care plan last revised in July 2016, which identified this resident, in different areas of the care plan, required conflicting levels of assistance with transfers. Additionally, for locomotion needs, it identified this resident used a mobility aid requiring conflicting levels of assistance.

On a specific day in October 2016, Inspector #621 observed resident #003 who was seated in their chair and was being returned to their room with the assistance of one staff member.

During an interview with PSW #105, they reported to Inspectors #196 and #621 that beginning in October 2016, PSW staff referenced "Individualized Resident Routine" documents found in a black binder at the nursing station for specific care needs of each resident. PSW #105 reported that they were aware of a centralized care plan binder containing written care plans for each resident, but that PSW staff did not have time to

look at written care plans, and PSW staff did not access the resident’s electronic health record.

Inspector #621 reviewed resident #003’s "Individualized Resident Routine" document which identified this resident required three types of mobility aids for ambulation, and transferred with assistance.

During an interview with RPN #102 on a specific day in October 2016, they verified to the Inspector that PSW staff referred to "Individualized Resident Routine" document for resident care needs, did not have access to the electronic health record, and did not refer to the written care plans found in the care plan binder. RPN #102 reported that RPN staff would refer to the written care plans for resident care needs and that the written care plans found in the care plan binder at the unit would be the most current.

During an interview with RPN #102, they reported to the Inspector that interventions for ambulation and transfers found on the "Individual Resident Routines" document for resident #003 was incorrect. RPN #102 also indicated that information pertaining to this resident’s transfer and locomotion needs on the “ADL Assistance” section of the written care plan was incorrect. RPN #102 confirmed with Inspector #621 that ambulation and transfer information documented on the PSW’s "Individual Resident Routine" document, and the "ADL Assistance" section of the July 2016, care plan did not set out clear directions to staff providing direct care to resident #003.

During an interview with Acting Nurse Manager #107 in October 2016, they reported to the Inspector that it was their expectation that the plan of care which included the written care plan was up-to-date and consistent with the current care needs of residents. [s. 6. (1) (c)] (621)

2. During the inspection, resident #004 was identified to have areas of altered skin integrity.

The health care records of resident #004 were reviewed by Inspector #196 for information regarding wound care. The "Individual Resident Routines" document, as used by the PSW staff, did not identify information regarding altered skin integrity and noted a specific type of bath routine. The written care plan included a focus of altered skin integrity, but did not identify if there was any current altered skin integrity or treatment information. The current Medication Administration Records (MAR) included a treatment for the resident's altered skin integrity.

During an interview conducted with RPN #102 on a day in October 2016, they reported to Inspector #196 that resident #004 had altered skin integrity and required a specific bath care routine. In addition, RPN #102 confirmed to the Inspector that the current care plan and the PSW "Individual Resident Routines" document did not reference the resident's altered skin integrity, so staff would not be aware of the resident's care needs.

On a specific day in October 2016, an interview was conducted with Nursing Manager #108, and they confirmed that the "Individual Resident Routines" document for residents should have had information regarding skin care. [s. 6. (1) (c)] (196)

3. During the inspection, resident #005 was identified to have had a specific weight status with no plan.

Inspector #621 reviewed resident #005's written care plan, last revised in July 2016, which identified that this resident was to be provided with a nutrition intervention. On review of this resident's diet census there was no information identifying resident #005 to require any nutrition intervention. Furthermore, a review of the physician orders from resident #005's chart indicated that nutrition interventions had been discontinued since August 2016.

During an interview with RPN #102 on a specified day in October 2016, they indicated that information pertaining to this resident's need for a nutrition intervention would be found in the orders of this resident's chart, and in their written care plan. RPN #102 confirmed that a specific nutrition intervention had been discontinued in August 2016, but that the written care plan had not been updated after a specific date in July 2016, to reflect the change in this resident's care needs. Consequently, RPN #102 identified that the written care plan did not set out clear directions to staff providing direct care to resident #005 with regards to nutrition intervention needs. [s. 6. (1) (c)] (621)

4. During the inspection, resident #008 was identified to have altered skin integrity.

The health care records for resident #008 were reviewed by Inspector #196 for information regarding the altered skin integrity. The current care plan included interventions aimed at reducing the risk of developing altered skin integrity and for treatment if required. The "Individual Resident Routine" document as found in the PSW binder did not include information identifying altered skin integrity or the risk for altered skin integrity.

On a specific day in October 2016, an interview was conducted with PSW #110 and they reported that PSW staff in the home referred to the "Individual Resident Routines" document for information about a resident and they didn't look at the care plans.

An interview was conducted with RPN #102 and they reported that resident #008 had altered skin integrity.

On a specific day in October 2016, Inspector #196 conducted an interview with Nurse Manager #108 and they confirmed that the "Individual Resident Routines" document was not complete and updated with consistent information, and consequently did not provide clear direction. [s. 6. (1) (c)] (196)

5. During the inspection, resident #001 was identified to have had a specified number of falls.

Inspector #621 reviewed resident #001's written care plan, last revised in July 2016, and noted that this resident required conflicting levels of assistance with their care needs.

Inspector #621 reviewed resident #001's "Individualized Resident Routine" document which identified conflicting information with interventions in the care plan. Under a specific section of the "Individualized Resident Routine" document, it was recorded that this resident required a particular routine completed a specified times that was different than what was identified in the written care plan.

During an interview with RPN #102, they reported that the specific routine in resident #001's plan of care was incorrect and that information found on the "Individualized Resident Routines" document for this resident was consistent with what care was being provided by PSW staff. They also identified that the care plan document was incorrect in regards to the assistance the resident required and use of specific mobility aids. RPN #102 identified to Inspector #621 that the "Individual Resident Routines" document for resident #001 with regards to transferring did not identify this resident's current care needs, and should have. RPN #102 confirmed to the Inspector that both the resident's written care plan document, last revised in July 2016, and the "Individualized Resident Routines" document did not provide clear direction to staff who provided care to resident #001 with respect to their care needs. [s. 6. (1) (c)] (621)

6. During an interview on a specific date in October 2016, RPN #104 reported to

Inspector #621 that resident #002 had a fall.

During an interview with resident #002 on a specific day in October 2016, they reported to the Inspector that they were using a mobility aid in certain circumstances, but used a another type of mobility aid for other circumstances.

During an interview with RPN #103, they reported to the Inspector that this resident used a specific type of mobility aid. RPN #103 indicated that the resident preferred to use this mobility aid when attending activities. RPN #103 also identified staff provided assistance with transfers.

Inspector #621 reviewed resident #002's written care plan, last revised in May 2016, and noted that in different sections of the care plan there was conflicting information regarding locomotion and transfers for this resident.

Inspector #621 reviewed "Individualized Resident Routine" document for resident #002 which identified that this resident was independent with use of a mobility aid for ambulation, but it was not documented that the resident also used another type of mobility aid. Additionally, the "Individualized Resident Routine" document did not identify the resident's requirements with transfers.

During an interview with RPN #102, they reported that information pertaining to resident #002's transferring requirements and use of mobility aids for locomotion from their written care plan was incorrect. RPN #102 also reported that the "Individual Resident Routines" document for resident #002 did not identify this resident required a mobility aid and requirements with transfers, and should have. RPN #102 further indicated that the written care plan document, last revised in May 2016, was the most current and that had been no care plan updates after September 2016. Consequently, RPN #102 confirmed to the Inspector that both the written care plan document and the "Individualized Resident Routines" document did not provide clear direction to staff who provided care to resident #002 with respect to transferring and locomotion requirements. [s. 6. (1) (c)] (621)

7. During the inspection, resident #007 was identified to have a medical device.

The health care records of resident #007 were reviewed for information regarding the use of a medical device. The "Individual Resident Routines" document did not identify the use of a medical device. The care plan however, included a focus and specific interventions associated with use of the medical device.

On a specific day in October 2016, Inspector #196 conducted an interview with RPN #101 and they reported that resident #007 required a medical device for a specific medical condition, although there was no current medical condition identified in their plan of care.

In another interview with RPN #102 on a specific day in October 2016, they confirmed to the Inspector that the "Individual Resident Routines" document did not include the use of the specified medical device.

On another day in October 2016, Inspector #196 conducted an interview with Nurse Manager #108 and they confirmed that the "Individual Resident Routines" document was not complete and updated with consistent information, and consequently did not provide clear direction. [s. 6. (1) (c)] (196)

8. During the inspection, resident #007 was identified to have altered skin integrity.

The health care records of resident #007 were reviewed by Inspector #196 for information regarding skin integrity. The "Individual Resident Routines" document, as used by the PSW staff, did not identify skin integrity concerns, as confirmed by RPN #102. The care plan however, included a focus identifying altered skin integrity.

On a specific day in October 2016, Inspector #196 conducted an interview with RPN #101 and they reported that resident #007 had skin issues although there was no current skin breakdown.

On the same day in October 2016, Inspector #196 conducted an interview with Nurse Manager #108 and they confirmed that the "Individual Resident Routines" document was not complete and updated with consistent information, and consequently did not provide clear direction regarding skin concerns. [s. 6. (1) (c)] (196)

9. On a specific day in October 2016, Inspector #916 observed resident #004 seated in their mobility aid with a safety device in place.

The health care records of resident #004 were reviewed by Inspector #196 for information regarding use of a safety device. The "Individual Resident Routines" document, as used by PSW staff, identified the use of a safety device as required. The current care plan included a focus which identified use of a safety device as a restraint.

The physician order dated from July 2016, identified a specific safety device to be applied while the resident was in their mobility aid.

On a specific day in October 2016, Inspector #196 conducted an interview with RPN #102 and they reported that resident #004 used one type of safety device, and that another type of safety device was no longer used.

In October 2016, Inspector #196 conducted an interview with Nurse Manager #108 and they confirmed that the "Individual Resident Routines" document was not complete and updated with consistent information regarding the restraint, and consequently did not provide clear direction. [s. 6.(1) (c)] (196)

10. 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.

During the inspection, resident #005 was identified by Inspector #196 to have previously used a medical device.

The health care records for resident #005 were reviewed by Inspector #196 for information regarding the use of a medical device. The current care plan included the focus which identified the use of a medical device beginning on a specific day in June 2016, and the need for it to be reassessed on a subsequent day in July 2016, with the goal that the medical device be maintained, and interventions which identified that staff were to maintain the medical device as per policy and as needed. The "Individual Resident Routines" document identified the use a specific product for a medical condition, but that there was no reference for the use of a medical device for the same medical condition. Additionally, the progress notes identified that the medical device was removed on a later date in July 2016.

On a specific date in October 2016, Inspector #196 conducted an interview with RPN #103 and they reported that resident #005 no longer had a medical device in place, and the plan of care had not been updated to reflect this. [s. 6. (10) (b)] (196)

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) there is a written plan of care for residents' #001, #002, #003, #004, #005, #007 and #008 that sets out clear directions to staff and other who provide direct care to these residents relating to falls prevention, skin and wound management, nutrition and hydration, continence care and bowel management; and b) that resident #005 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, resident #005's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances or the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During a review of resident #003's records for a fall which occurred in September 2016, Inspector #621 could not find a completed post fall assessment for this resident.

A review of the home's policy titled "Falls Prevention Program", last revised September 29, 2015, identified that under the standard operating procedures for post fall assessment and management, registered nursing staff were to complete the "Post Fall Screening Tool" when a resident had a fall.

On a specific day in October 2016, RPN #102 reported to Inspector #621 that a "Post Falls Screening Tool" was to be completed after every fall. RPN #102 indicated that post fall documentation, with exception of the incident being recorded in the progress notes of the electronic medical record (EMR), was kept in paper copy on the resident's chart.

RPN #102 reported to the Inspector that they completed a review of resident #003's plan of care, which included the resident's chart and identified that the most recent fall occurred on a specific day in September 2016, and that a "Post Fall Screening Tool" had not been completed.

During an interview with Inspector #621 on a specific day in October 2016, Acting Nurse Manager #107 reported that it was the home's expectation that registered staff complete a post fall assessment for all resident falls. [s. 49. (2)] (621)

2. During a review of resident #001's documentation for a specified number of falls which occurred in September and October 2016, Inspector #621 could not find a completed post fall assessment.

During an interview with Inspector #621, RPN #102 identified that the most recent falls for this resident occurred in September and October 2016, and that a "Post Fall Screening Tool" for each fall had not been completed. [s. 49. (2)] (621)

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 has fallen, the resident is assessed and that where the condition or circumstances or the resident required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

During a review of resident #005, and #003's plans of care on a specific day in October 2016, Inspector #621 identified that the most current Registered Dietitian (RD) quarterly assessments for these residents were documented during March and April 2016, respectively.

During an interview with RPN #102 on a specific day in October 2016, it was reported to the Inspector that the home's RD had been off work since May 2016, and there had been no onsite RD services provided to the home until the RD returned to work approximately one month ago.

RPN #102 also reported that a quarterly nutrition review and nutrition care plan update by an onsite RD had not been completed for resident #005 and #003 since their last review documented in March and April 2016, respectively.

During an interview on a specific day in October 2016, it was reported by Acting Nurse Manager #107 to the Inspector that the home's RD had been off work from mid-May until August, 2016 and indicated that the home did not have a backup RD to provide onsite clinical and nutrition care duties during this time to meet legislative requirements. [s. 74. (2)] (621)

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 registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

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

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: The person who applied the device and the time of application.

On a specific day in October 2016, resident #003 was observed by Inspector #196 to be seated in a mobility aid with a safety device in place.

The health care records for resident #003 were reviewed by Inspector #196 for information regarding the use of the safety device. The current care plan identified the use of the safety device as a restraint for resident #003. The "Restraint Monitoring Record" for the month of October 2016 was reviewed. On a specific day in October 2016, the time of application of the restraint was not documented, yet the initials of the RN/RPN

who made the decision to apply the restraint were documented.

On a specific day in October 2016, Inspector #196 conducted an interview with RPN #103 regarding restraint documentation. They reported that registered nursing staff were to complete the restraint documentation when the restraint was applied or removed, the resident was repositioned, and when the restraint was checked by a another staff member.

An interview was conducted with Nurse Manager #108 on a specific day in October 2016, and they confirmed that registered nursing staff were to complete the documentation regarding restraint use. [s. 110. (7) 5.] (196)

2. On a specific day in October 2016, resident #006 was observed by Inspector #196 to be seated in their mobility aid with a safety device in place.

The health care records for resident #006 were reviewed by Inspector #196 for information regarding the use of the safety device. Specifically, a "Restraint Monitoring Record" for the month of October 2016 was reviewed and it was identified by the Inspector that on a specific day in October 2016, that the time of application of the safety device was not documented, yet the initials of the RN/RPN who made the decision to apply the safety device were documented.

An interview was conducted by Inspector #196 with RPN #102 on a specific day in October 2016. They confirmed to the Inspector that resident #006 had a safety device, and that the resident was unable to remove it. [s. 110. (7) 5.] (196)

3. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: All assessment, reassessment and monitoring, including the resident's response.

On two days in October 2016, resident #006 was observed by Inspector #196 to be seated in a mobility aid with a safety device in place.

An interview was conducted by Inspector #196 with RPN #102 on a specific day in October 2016. They confirmed that resident #006 had a specific type of restraint and that the resident was unable to remove it.

The health care records for resident #006 were reviewed for information regarding the use of the restraint. The "Restraint Monitoring Record" for the month of October 2016 was reviewed. On a specific day in October 2016, the Inspector found no documentation of restraint checks and repositioning for a nine hour period. In addition, the initials of the registered nursing staff member who made the decision for application of the restraint on the day shift of that same day was not documented.

On another day in October 2016, there was no documentation of the restraint checks, repositioning or resident response from 1600hrs through the rest of the evening shift. In addition, the initials of the registered nursing staff member who made the decision for the application of the restraint for the evening shift on that same day, was not documented. [s. 110. (7) 6.] (196)

4. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

On a specific day in October 2016, resident #003 was observed by Inspector #196 to be seated in a mobility aid with a safety device in place.

An interview with PSW #110 on a specific day in October 2016, confirmed to the Inspector that resident #003 had a specific type of safety device which was a restraint.

The health care records for resident #003 were reviewed by Inspector #196 for information regarding the use of the restraint. Specifically, the "Restraint Monitoring Record" for the month of October 2016 was reviewed and found that on two days in October 2016, the time of the removal of the restraint device was not documented. [s. 110. (7) 8.] (196)

5. On a specific day in October 2016, resident #006 was observed by Inspector #196 to be seated in their mobility aid with a safety device in place.

The health care records for resident #006 were reviewed by Inspector #196 for information regarding the use of the restraint. Specifically, a "Restraint Monitoring Record" for the month of October 2016 was reviewed, and it was identified that on a specific day in October 2016, the time of removal of the restraint device was not

documented.

An interview was conducted by Inspector #916 with RPN #102 on a specific day in October 2016. They confirmed to the Inspector that resident #006 had a specific type of restraint, and that the resident was unable to remove it. [s. 110. (7) 8.] (196)

6. On a specific day in October 2016, resident #004 was observed by Inspector #196 to be seated in a mobility aid with a safety device in place.

An interview was conducted by Inspector #196 with RPN #102 on October 6, 2016. They confirmed to the Inspector that resident #004 had a specific type of restraint and that the resident was unable to remove it.

The health care records for resident #004 were reviewed by the Inspector for information regarding the use of the restraint. Specifically, the "Restraint Monitoring Record" for the month of October 2016 was reviewed, and it was identified that on a specific day in October 2016, the time of removal of the restraint device was not documented. [s. 110. (7) 8.] (196)

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 use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following is documented: a) the person who applied the device and the time of application; b) all assessment, reassessment and monitoring, including the resident's response; and c) the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances are stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On a specific day in October 2016, Inspector #196 observed a container of a controlled substance on the counter at the nursing desk. The nursing desk was not secure and the container was within reach of any person that may have entered.

Inspector #196 conducted an interview with RN #111, and they reported that this bottle of medication was for a new resident admission and should have been locked in the medication room. [s. 129. (1) (b)] (196)

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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy to minimize the restraining of residents and to ensure that any restraining that was necessary was done in accordance with this Act and the regulations were complied with.

On a specific day in October 2016, resident #003 was observed by Inspector #196 to be seated in their mobility aid with a safety device in place.

The health care records for resident #003 were reviewed for information regarding the use of a restraint. The current care plan included the focus of restraints with applicable restraint use and monitoring interventions. The most recent Resident Assessment Instrument Material Data System (RAI MDS) assessment identified the daily use of a restraint. The most current physician's orders and quarterly medication review dated August 2016 did not include an order for the use of a restraint. The resident's thinned chart contained an order dated from August 2015 for a restraint.

The home's policy titled "RN Application of a Restraint Procedure - NUR_R_130", last revised April15, 2013, was reviewed by Inspector #196. The policy identified that for long term care residents, the restraint orders and the decision to continue or discontinue a restraint was to be done quarterly.

On a specific day in October 2016, Inspector #196 conducted a telephone interview with Nurse Manager #108.They reported that the physician's quarterly medication review was the current physician's orders and should have included an order for the use of a restraint for resident #003. [s. 29. (1) (b)] (196)

2. On a specific day in October 2016, resident #006 was observed by Inspector #196 to be seated in their mobility aid with a safety device in place.

The health care records for resident #006 were reviewed for information regarding the use of a restraint. The current care plan did not include reference to the use of a safety device as a restraint. Specifically, the “Restraint Monitoring Record” for October 2016 noted the use of a safety device that the resident could not undo. Further, the current physician's orders and quarterly medication review dated from August 2016 did not include an order for the use of a restraint. The resident's thinned chart contained an order dated from September 2015, for an as needed restraint.

On a specific day in October 2016, Inspector #196 conducted an interview with RPN #102 and they confirmed that resident #006 had a restraint in use.

On another day in October 2016, Inspector #196 conducted a telephone interview with Nurse Manager #108. They reported to the Inspector that the physician's quarterly medication review was the current physician's orders and should have included an order for the use of a restraint for resident #006. [s. 29. (1) (b)] (196)

WN #7: 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 a copy of the service accountability agreement

as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network, was communicated in a manner that complied with any requirements that may be provided in the regulations, to residents who cannot read the information.

During a review of the completed Admission Process Long-Term Care Home (LTCH) Licensee Confirmation Checklist on a specific day in October 2016, Inspector #621 identified that Acting Nurse Manager #107 had checked off that a copy of the home's service accountability agreement was not posted in the home.

During an interview on that same day, Acting Nurse Manager #107 confirmed to the Inspector that the home had a copy of most recent service accountability agreement between the licensee and the North West Local Health Integrated Network, but it had not been posted on the bulletin board in the hallway where posting of other required information was kept easily accessible to residents.

This finding of non-compliance was associated specifically with the Long-Term Care Homes Act (LTCHA), 2007. s.79.(3)(g.1). [s. 79. (3)] (621)

2. The licensee has failed to ensure that the most recent minutes of the Family Council meetings, with consent of the Family Council was posted in the home, in a conspicuous and easily accessible location.

During a tour of the home, Inspector #621 reviewed a copy of the Family Council minutes from October 2015, which was posted on a bulletin board in the hallway adjacent to the common room.

During an interview with the Family Council President on a specific day in October 2016, it was identified that the Family Council last met in May 2016. The Family Council President identified that copies of all Family Council minutes were sent to the Nurse Manager by the Family Council secretary. It was reported that the Nurse Manager kept copies of the Family Council minutes in a binder in their office and posted a copy of the most recent minutes of Family Council with Family Council consent in the home.

Inspector #621 obtained the Family Council binder from Administrative Assistant #112 and reviewed its contents. The binder contained copies of minutes from Family Council meetings up to and including the minutes from May 2016.

During an interview with Administrative Assistant #112 on a specific day in October 2016, they identified that the most current minutes of Family Council from May 2016, were to be posted in the home on the bulletin board.

Together the Inspector and Administrative Assistant #112 reviewed the bulletin board where the Family Council minutes were to be posted and instead identified minutes from October 2015. Administrative Assistant #112 confirmed to the Inspector that the only Family Council minutes posted were from October 2015, and these were not the most current minutes of Family Council.

During an interview Acting Nurse Manager #107, they identified that it was their expectation that the most current minutes of Family Council were posted in the home. [s. 79. (3) (o)] (621)

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including the following: Access to these areas shall be restricted to, persons who may dispense, prescribe or administer drugs in the home.

On a specific day in October 2016, Inspector #196 observed Housekeeping Aide #109 mopping the medication room floor, unattended, and had access to the drug supply. They reported to Inspector #196 that RPN #101 let them into the medication room to do the cleaning, and RPN #101 then left to attend to a resident.

Inspector #196 conducted an interview with RPN #101 and they reported that they had opened the medication room for the Housekeeping Aide to do cleaning and then went to assist a resident. They also reported that the narcotics were locked up in the medication cart. RPN #101 then confirmed to the Inspector that other medication, including resident medications and government stock medication was within the room and not secured.

An interview was conducted with Acting Nurse Manager #107 regarding the Housekeeping Aide having access to the drug supply in the medication room. The Acting Nurse Manager #107 confirmed to the Inspector that the Housekeeping Aide should not have had unsupervised access to the medication room. [s. 130. 2. i.] (196)

WN #9: 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.

On a specific day in October 2016, Inspector #196 observed RPN #101 perform a diagnostic test on resident #009 prior to the administration of a medication.

The health care records for resident #009 were reviewed. The current physician's order identified this resident was to have a specified number and type of diagnostic tests completed daily. A review of the record kept of the specific diagnostic tests for resident #009 had a space where a test result for a specific time on a day in October 2016 should have been documented and was not.

An interview was conducted with RPN #101 on the same day in October 2016, and they confirmed that a result of a diagnostic test was not recorded on the designated record at the specific time identified by the Inspector. They also reported that they had not received this information at shift report either.

On a specific day in October 2016, an interview was conducted with Acting Nurse Manager #107 regarding the physician's order for the specified diagnostic testing and the absence of documentation for a specific time on the identified date in October 2016. Acting Nurse Manager #107 confirmed that the physician's order was to complete a specified number and type of diagnostic tests on resident #009 daily and that documentation was incomplete for when one of the diagnostic tests that was to be completed, and therefore they were unable to confirm that the test had been completed as ordered by the physician. [s. 134. (a)] (196)

Issued on this 2nd day of January, 2017

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

Original report signed by the inspector.