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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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 15, 2014	2014_168202_0025	T-86-14	Resident Quality Inspection

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

RIVER GLEN HAVEN NURSING HOME
160 High Street P.O. Box 368 Sutton West ON L0E 1R0

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

VALERIE JOHNSTON (202), GORDANA KRSTEVSKA (600), JUDITH HART (513), SOFIA DASILVA (567)

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 24, 27, 28, 29, 30, 31 and November 03, 04, 05, 06, 2014.

During the course of this inspection the following Critical Incident Inspection were completed. T-1323-14,T-669-13, T-1322-14, T-719-13, T-1301-14 and T-682-13.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), dietitian, environmental services supervisor, physiotherapist, rai-coordinator, environmental services manager, registered nursing staff, personal support workers, housekeeper, dietary aide, president of Residents' Council, president of Family Council, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff only apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class.

Resident #08 was observed on October 29, 2014, from 11:30 a.m. to 2:00 p.m., sitting in a tilted wheelchair with a side closing seat belt. The resident was observed to be in bed with two full length side rails raised on October 30, 2014 from 8:30 a.m. to 2:30 p.m. Resident #08's clinical record review revealed and staff interview confirmed that the side rails and the use of a tilt wheelchair are considered a restraint for the resident. Staff confirmed that there was no order or approval by a physician or registered nurse in extended class to apply the above physical restraint devices. [s. 110. (2) 1.]

2. The licensee has failed to ensure that where a resident is being restrained by a

physical device under section 31 of the Act, that the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

Resident #08 was observed on October 29, 2014 from 11:30 a.m. to 2:00 p.m., sitting in a tilted wheelchair with a side closing seat belt. The resident was observed to be in bed with two full length side rails raised on October 30, 2014 from 8:30 a.m. to 2:30 p.m. Resident #08's clinical record review revealed and staff interview confirmed that the side rails and the use of a tilt wheelchair are considered a restraint for the resident. Staff confirmed that the resident is not monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff. [s. 110. (2) 3.]

3. The licensee has failed to ensure that where a resident is being restrained by a physical device under section 31 of the Act: 6., the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Resident #08 was observed on October 29, 2014 from 11:30 a.m. to 2:00 p.m., sitting in a tilted wheelchair with a side closing seat belt. The resident was observed to be in bed with two full length side rails raised on October 30, 2014 from 8:30 a.m. to 2:30 p.m. Resident #08's clinical record review revealed and staff interview confirmed that the side rails and the use of a tilt wheelchair are considered a restraint for the resident. Resident # 8's record review and staff interview indicated that there was no reassessment and effectiveness of the restraining evaluated by a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [s. 110. (2) 6.]

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 staff only apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class, the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose and that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On October 24 and 29, 2014, the versa frame surrounding the toilets in rooms 215, 217 and the tub room on second floor were found to be loose. Staff interviews confirmed that the versa frame's attached to the toilets in the above mentioned rooms were loose and that the versa frame in the tub room would be unsafe for resident use. An identified RPN indicated that a maintenance request had been initiated to tighten the above mentioned versa frames. [s. 15. (2) (c)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a plan of care based on at a minimum, interdisciplinary assessment with respect to the resident's vision.

A review of resident #08's plan of care last updated on September 30, 2014, does not identify care with respect to the resident's vision. An interview with a registered nurse confirmed that the plan of care for resident #08 did not include vision care. [s. 26. (3) 4.]

WN #4: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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.

The plan of care for resident #09 identified the resident as having altered skin integrity, including skin tears and multiple wounds. A review of the resident's progress notes for an identified period of time, indicated that he/she had skin tears and wounds on identified dates.

Interviews with registered staff and the DOC confirmed that resident #09's skin tears and wounds noted on the above identified dates had not been assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

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

The plan of care for resident #09 identified the resident as having altered skin integrity,

including skin tears and multiple wounds. A review of the resident's progress notes for an identified period of time indicated that he/she had skin tears and wounds on identified dates.

Interviews with registered staff and the DOC confirmed that a resident identified with altered skin integrity, including redness, skin tears and wounds are to be assessed by registered staff weekly using a skin and wound summary note. The DOC confirmed that resident #09's skin tears and wounds noted above had not been assessed weekly by a member of the registered nursing staff as clinically indicated. [s. 50. (2) (b) (iv)]

3. A review of the MDS assessments for resident #12 revealed that the resident had skin integrity concerns at the time of an MDS assessment on an identified date. In addition, the resident had further skin integrity concerns at the time of the resident's next MDS assessment, on an identified date.

A review of the progress notes revealed that the resident's skin integrity concern was assessed by a member of the registered nursing staff on identified dates.

Interview with the registered staff and the DOC confirmed that the pressure ulcer was not reassessed weekly and that it should have been. [s. 50. (2) (b) (iv)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviour are developed to meet the needs of residents with responsive behaviours.

Clinical record review revealed that resident #31's progress notes for an identified period of time, indicated that the resident had been expressing inappropriate behavior, including physical aggression towards staff and other residents. Staff interviews indicated that the resident is resistive to care and becomes more aggressive during care.
Review of the resident's care plan does not include or identify any responsive behaviours exhibited by the resident. Staff confirmed that the resident's care plan does not include written strategies or interventions to respond and meet the needs of the resident's sexually inappropriate behaviours. [s. 53. (1) 1.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The minutes of the Residents' Council were reviewed from September 2013 to September 2014. Included in the minutes were Residents' Council Concern Forms identifying the issue/concern raised at the council, the responsible manager's response, signed off by the administrator.

The assistant to the Residents' Council and the administrator indicated in interviews that the Resident Council Concern Form is read to the council members at the next scheduled meeting and is not received by Residents' Council within 10 days. [s. 57. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond to the Family Council in writing within 10 business days of receiving Family Council advice related to concerns or recommendations about the operation of the home.

An interview with the Family Council president revealed that at Family Council meetings, the council had requested information from the home related to the fire sprinkler, the home's fire plan, volunteer training, confidentiality and advice regarding Christmas dining for residents, with no response.

Interview with the Administrator confirmed no knowledge of the above concerns, and that the home has not responded in writing to these concerns or advice to the Family Council. [s. 60. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey.

Interview with the Family Council president and the administrator confirmed that the home has not sought the advice of the Family Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

2. The licensee failed to ensure that the Residents' Council receive the results of the satisfaction survey in order to seek the advice of the Council about the survey.

The Residents' Council minutes were reviewed from October 2013 to September 2014 and there were no notations in the minutes regarding Councils' review of satisfaction survey results for 2013.

The Residents' Council president, council assistant and administrator indicated in interviews that satisfaction survey results were not brought before the council to seek its members' advice. [s. 85. (4) (a)]

3. The licensee has failed to ensure that the results of the satisfaction survey are documented and made available to the Family Council to seek their advice.

Interviews with the Family Council president and the administrator confirmed that the home has not made available the results of the survey to the Family Council. [s. 85. (4) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day of an incident that causes an injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition.

A review of the clinical records for resident #51 indicated that the resident was found on the floor in his/her room on an identified date. The resident was sent immediately to hospital for further assessment and admitted with a diagnosis of a fracture requiring surgery. The resident returned to the home and passed away two days later. An interview with the DOC confirmed that the Director was informed of the above incident, 10 days after the injury which resulted in a significant change in resident #51's health condition. [s. 107. (3) 4.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in skin and wound care.

An interview with the DOC confirmed that the home had not provided staff with training on skin and wound care in 2013, however, a training session is planned for personal support workers in November 2014. [s. 221. (1) 2.]

Issued on this 16th day of December, 2014

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

Original report signed by the inspector.