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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 25, 2015	2015_195166_0020	O-001894-15, 001976-15, 002007-15, 002008-15, 002614-15	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

RIVERVIEW MANOR NURSING HOME
1155 WATER STREET PETERBOROUGH ON K9H 3P8

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 17, 18, 19, 2015

Complaint Logs O-001894-15 and O-001976-15 were inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Program staff, Administrator, Director of Care, RAI Coordinator, Personal Support Workers, Registered Nurse and Registered Practical Nurses. During the course of the inspection, the inspectors observed staff to resident interactions, resident activities and programs, reviewed clinical records and the licensee's investigations related to resident falls, safe transfer and positioning devices.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. Log O-002614-15

The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs.

A Critical Incident (CIR) was received reporting an injury to Resident #9, which required the resident to be transferred to hospital for further treatment.

The CIR report indicated that Resident #9 sustained an injury while being transported in the wheelchair by a Personal Support Worker.
The Personal Support Worker did not report the incident immediately.
In the evening, post incident, a staff member reported that Resident #9 had complained of pain.

The morning following the incident, Resident #9 was assessed. The resident's mobility was noted to be decreased and pain was described as moderate to severe.
Resident #9 was transferred to the hospital for further assessment and treatment.

Review of clinical documentation, the licensee's investigation and interview with the Administrator and Director of Care indicated that when the resident complained pain in the evening, post incident, the resident was not assessed until the following morning. [s. 6. (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 the plan of care is based on an assessment of the resident and the resident's needs, specifically when the resident has complaints of discomfort and/or pain, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Log O-002614-15

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident (CIR) was received reporting that Resident #9 sustained an injury while being transported in the wheelchair by a Personal Support Worker.

Review of the CIR report indicated, Resident #9 was being transported in the wheelchair by a Personal Support Worker, when the resident sustained an injury that required further assessment and treatment at the hospital.

Review of the Resident #9 's plan of care related to Aids to Daily Living indicated :
-Foot pedals are to be placed on the wheelchair when resident is being ported out of their room to meals or activities.

On the day of the reported incident, the foot pedals were not placed on Resident #9's wheelchair as directed in the residents plan of care.
[s. 36.]

2. Log O-002008-15

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Critical Incident (CIR)2722-00011-15 was received reporting a resident fall.

The CIR documentation indicated that the resident was transferred and admitted to hospital to the hospital for further assessment, treatment and monitoring.

The resident's plan of care related to safety directed staff :
-to ensure the wireless alarm is on and functioning when the resident is in the wheelchair, recliner and when in bed.
-staff to ensure that posey alarm is in good working order at all times
-ensure that posey is applied appropriately

Review of clinical documentation , the licensee's policy,CS-12.1,-Resident Falls, interview with the Director of Care and Personal Support Workers indicated that at the time of the incident, Resident #2 was sitting in the wheelchair, the wireless alarm was not on, and the posey alarm was unclipped. [s. 36.]

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 are aware of the interventions related to safe transfers and use of equipment as indicated in residents' plans of care and that staff follow the plan and use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 25th day of August, 2015

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

Original report signed by the inspector.