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 sions 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
Jun 1, 2016	2016_389601_0010	013327-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

KARYN WOOD (601), CHANTAL LAFRENIERE (194), DENISE BROWN (626), LYNDA BROWN (111), SUSAN DONNAN (531)

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): May 16, 17, 18, 19, 20, 24, 25, 26, 2016.

The following logs were inspected during the Resident Quality Inspection (RQI):

Critical incident number M2722-000011-16 (log #011238-16) submitted by the home regarding resident to resident altercation.

Critical incident numbers M2722-000005-16 (log #008606-16) and M2722-000012-16 (log #014163-16) submitted by the home regarding a fall resulting in a transfer to hospital.

Critical incident numbers M2722-000032-15 (log #032113-15) and M2722-000009-15 (log #006546-15) submitted by the home regarding controlled substance unaccounted/missing.

Critical incident numbers M2722-000030-15 (log #029522-15) and M2722-000028-15 (log #023967-15) submitted by the home regarding allegations of abuse to a resident.

On site inquiry was completed related to critical incident numbers M2722-000034-15 (log #035594-14) and M2722-000036-15 (log #035578-15) submitted by the home regarding misuse/misappropriation of money.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Manager Resident Quality (MRQ), RAI Coordinator (RAI), Resident Service Coordinator (RSC), Office Manager (OM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Families, Resident Council President, Family Council Representative. The inspectors also conducted a tour of the home, observed meal services, medication administration, reviewed health care records, investigations by the homes, family and resident council minutes, and applicable policies.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

- **6 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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 the care set out in the plan of care for resident #004 was provided to the resident as specified in the plan related to falls prevention.

Log #014163-16 related to resident #004:

On an identified date and time, RPN #121 observed resident #004 enter the nurse's station walking with a mobility aide and no staff assistance. Resident #004 proceeded to leave the nurse's station without the mobility aide and staff assistance. RPN #121 observed resident #004 walk around the nurses station and trip over another resident's foot resulting in the resident falling to the floor. Resident #004 was transferred to the hospital for assessment and was diagnosed with an injury.

Review of resident #004's care plan interventions at the time of the fall included to ensure that resident #004's mobility aide was within reach at all times and that staff provide resident #004 with extensive assistance while walking.

During an interview, the ADOC and RPN #110 indicated that resident #004 had fallen on two occasions just prior to the identified incident and was being monitored every fifteen minutes due to resident #004's increased risk for falls. It was also identified that resident #004 required the mobility aide and staff assistance at all times while walking.

Therefore, RPN #121 did not ensure that resident #004 was using the identified mobility aide and did not provide resident #004 with the staff assistance required as specified in the plan of care related to high risk for falls on the identified date. [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 care set out in the plan of care for resident #004 is provided to the resident as specified in the plan related to falls prevention, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident shower had a least two easily accessible grab bars, with at least one grab bar being located on the same wall as the facet.

During the initial tour of the home on an identified date, it was observed that there were no accessible grab bars on the same wall as the facet in four of the showers located in the bathing rooms. [s. 14.]

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 resident shower has a least two easily accessible grab bars, with at least one grab bar being located on the same wall as the facet, to be implemented voluntarily.

WN #3: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance.

Log #006546-15 related to resident #014:

A critical incident report (CIR) was received by the Director on an identified date for a missing controlled substance that occurred five days prior. The CIR indicated during the medication narcotic count by RN #109 and RN #111 at 07:00, had noted a missing vial of an identified controlled substance.

Interview of the Administrator and ADOC indicated the Director was not notified until the CIR was submitted five days later. [s. 107. (3)]

2. The licensee has failed to ensure that the written report included the name of the resident that was involved in the missing or unaccounted for controlled substance.

Log #006546-15 related to missing medication:

A critical incident report was received by the Director on an identified date for a missing controlled substance that occurred five days prior. The CIR indicated during the medication narcotic count by RN #109 and RN #111 at 07:00, had noted a missing vial of an identified controlled substance from the locked box. The CIR did not identify any resident.

Interview of the Administrator and ADOC indicated the missing vial of the identified controlled substance belonged to resident #014. [s. 107. (4) 2.]

3. The Licensee has failed to make a report in writing to the Director setting out the following in respect to the incident. A description of the individuals involved in the incident, including, names of any staff members or other person who were present at or discovered the incident.

Log #023967-15 related to resident #015:

The home did not document the name of PSW #130 who was involved in the alleged physical abuse of resident #015 in the critical incident report (CIR) provided to the Director on an identified date.

The Administrator confirmed that the CIR did not identify PSW #130 who was involved in the alleged physical abuse of resident #015. [s. 107. (4) 2. ii.]

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 Director is informed no later than one business day after the occurrence of an incident of missing or unaccounted controlled substances, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their policy related to medication administration was followed to ensure safe, effective administration of medications.

Re: Critical Incident Log # 006546-15 for resident #014:

Under O.Reg.79/10, s. 114(2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Review of the home's policy (supplied by Medical Pharmacy) "Ordering & Receiving Medication-The Drug Record Book" (4-1) indicated: under #3 Ensure the following information is recorded upon receiving a medication:
-quantify, prescription number, signature/initial of person receiving order , date order was received.

Review of the home's policy (supplied by Medical Pharmacy) "Monitored Medication-Combined Individual Monitored Medication Record with Shift Count" (6-7) indicated: under #5 At Shift change, two registered staff (leaving and arriving) together:
-count the actual quantity of medications remaining
-confirm actual quantity is the same as the amount recorded on the last entry of Quantity/Remaining
-record the date, time, quantity of medication and sign.

Interview of the Administrator and the ADOC indicated upon completion of the investigation into the identified missing controlled substance, that RN # 111 (who was involved in the incident) as well as other RNs, were not completing the narcotic/controlled substance shift count according to the home's policy and/or procedure. They indicated the locked box was either not opened to complete the accurate count and/or the vials were not checked and the home could not accurately determine when the controlled substance actually went missing. The ADOC also indicated there was no record of the two identified controlled substance vials that were received from the pharmacy to determine how long the vial was missing as the registered nursing staff had not signed them into the Drug Record Book as per the home's procedure. (111) [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Log #029522-15 related to resident #044:

On an identified date and time, resident #044 reported to the Nursing Administrative Services Manager (NASM) and Office Manager that staff #101 had caused the resident discomfort to a specified area during care.

During interview with inspector, the Administrator stated that the results of the abuse investigation were not reported to the Director when Critical Incident report was submitted. [s. 23. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Log #029522-15 related to resident #044:

On an identified date and time, resident #044 reported to the Nursing Administrative Services Manager and the Office Manager that staff #101 had caused the resident to have discomfort to a specified area during care.

Critical incident report was received by the Director on the following day for allegations of abuse.

During interview with inspector, the Administrator indicated that immediate reporting to the Director was not completed by the Nursing Administrative Services Manager and the Office Manager at the time the incident was reported by resident #044. The critical incident report was submitted by RPN #120 the following day.

Log #011238-16 related to resident #041 and #042:

On an identified date and time resident # 041 was witnessed physical abuse towards resident #042.

Critical incident report was received by the Director on the following day for allegations of abuse.

The Administrator indicated during an interview with inspector #194 that the Director was not immediately notified by the registered nurse on duty at the time of the incident of the witness physical abuse between resident # 041 and #042. The critical incident report was submitted by the Administrator the following day. [s. 24. (1)]

Issued on this 1st day of June, 2016

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

Original report signed by the inspector.