Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Mar 21, 2017	2017_590554_0002	034750-16	Complaint

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

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 10, to January 13, 2017

Intake #034750-16

Summary of Intake:
1) #034750-16 - Complaint - related to hospitalization and change of condition.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Office Manager, Resident Service Coordinator, Life Enrichment Coordinator, Manager of Resident Quality, RAI-Coordinator, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Registered Dietitian, and Family.

During the course of the inspection, the inspector, toured the long-term care home, reviewed the clinical health record, specific to resident #001; reviewed the Complaints Log binder, Licensee policies, specific to Complaints Procedure, Pain Assessments, and PRN Administration and Documentation.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
3 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care.

Substitute Decision Maker (SDM) #002 indicated (to the inspector, on January 09, 2017) that he/she questions the care and assessments provided to resident #001, by registered nursing staff and others, prior to resident #001, being hospitalized on an identified date. Substitute Decision Maker indicated that he/she was not consistently provided updates as to changes in resident #001's health condition.

Resident #001 was admitted to the long-term care home on an identified date. Resident #001's history includes, cognitive impairment.

According to the clinical health record, including the Face Sheet-Profile, Advanced Directives (reviewed and last signed on an identified date) and, several entries documented in the progress notes (written by registered nursing staff), Family #002 is the designated substitute decision maker (SDM) for resident #001. Substitute Decision Maker #002 indicated (to the inspector) that resident #001 is not capable of making care decisions on his/her own, and relies on him/her for such.

Registered Nurse #014, Resident Service Coordinator, Manager of Resident Quality, and the Director of Care indicated (to the inspector, on January 10, to January 13, 2017) awareness that Family #002 was designated SDM for resident #001.

Progress notes reviewed (by the inspector) for a period, of approximately one week, provide documentation that resident #001 was experiencing gastro-intestinal (GI) symptoms daily to several times per day, throughout this review period. According to progress notes, resident #001 complained of discomfort, had poor intake and was assessed by registered nursing staff to be anxious and hallucinating. Routine and as needed (PRN) medication for discomfort and/or GI symptoms were documented by registered nursing staff to be of minimal effect, to not effective in relieving resident’s symptoms.

On an identified date, the following progress notes are documented:
- At an identified hour – Resident Service Coordinator reported to Registered Practical Nurse-Manager of Resident Quality that resident #001 was anxious, hallucinating and

was requesting to go to hospital. Documentation indicates that registered nursing staff reported resident #001 had GI symptoms, and has not eaten today. Resident indicating repetitively that he/she was in discomfort and wanted help. Plan: Diagnostic tests were booked for an upcoming date. Medications needed time to take effect, and the resident #001 will not be sent to hospital as of this time. Staff to monitor.
- At a later time (specified) – Registered Practical Nurse was called to assist with resident #001; resident presenting distressed and stating having discomfort. Resident stating he/she was seeing people that weren’t there, and stated to nurse that he/she was feeling anxious.
- At a later time (specified) – Registered Nurse (RN) #014 indicated being called to resident #001’s room. Resident assessed as being anxious, complained of feeling sick, having shortness of breath and wanting to go to hospital. Resident has had GI symptoms most of day. Nurse administered routine medication and a PRN (as needed) anti-emetic. Report given by RN #014 to oncoming registered nursing staff, advising nursing staff to closely monitor resident.

Progress notes, reviewed, fail to provide supporting documentation that the SDM for resident #001 was notified of resident’s health condition during this review period.

Registered Nurse #014 indicated that SDM (Family #002) was not notified, on the identified date, of resident #001’s health condition. RN #014 indicated (to the inspector, on January 13, 2017) being aware that Family #002 was the designated substitute decision maker. RN #014 indicated that SDM was not notified, as resident #001 had asked that his/her family not be called.

Substitute Decision Maker indicated he/she was not notified of a decline in resident’s health until a specific date (and hour), at which time, resident #001 was transferred to hospital for assessment and treatment.

Resident was admitted to hospital on an identified date.

The substitute decision maker was not provided the opportunity to participate in the development and implementation of the plan of care prior to the resident being sent to the hospital. [s. 6. (5)]

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

Substitute Decision Maker (SDM) #002 indicated (to the inspector, on January 09, 2017) that he/she questions the care and assessments provided to resident #001, by registered nursing staff and others, prior to resident #001, being hospitalized on an identified date.

Resident #001 was admitted to the long-term care home on an identified date. Resident #001 has a history which includes, cognitive impairment.

The clinical health record, including the Face Sheet-Profile, and, several entries documented in the progress notes (written by registered nursing staff), indicated that SDM #002 is the designated substitute decision maker (SDM) for resident #001. Substitute Decision Maker #002 indicated (to the inspector) that resident #001 is not capable of making care decisions on his/her own, and relies on him/her for such.

The Director of Care confirmed (on January 10, 2017, with the inspector) that SDM #002 is the designated SDM for resident #001.

The “Management of Serious or Worsening Condition”, signed and dated (for a specific date, and is part of the clinical health record) by SDM direct the following:

- Level Four (4) – with serious deterioration, transfer to an acute care hospital with CPR.

Progress notes reviewed (by the inspector) for a period, of approximately one week, provide documentation that resident #001 was experiencing gastro-intestinal (GI) symptoms daily to several times per day, throughout this review period. According to progress notes, resident #001 complained of discomfort, had poor intake and was assessed by registered nursing staff to be anxious and hallucinating. Routine and as needed (PRN) medication for discomfort and/or GI symptoms were documented by registered nursing staff to be of minimal effect, to not effective in relieving resident’s symptoms.

On an identified date, the following progress notes are documented:
- At a specific hour – Resident Service Coordinator (RSC) reported to Registered Practical Nurse-Manager of Resident Quality that resident #001 was anxious, hallucinating and was requesting to go to hospital. Documentation indicates that registered nursing staff reported resident #001 had GI symptoms and has not eaten today. Resident indicating repetitively that he/she was in discomfort and wanted help. Plan: Diagnostic testing was booked for a specific date. Medications needed time to take effect, and that resident #001 will not be sent to hospital as of this time. Staff to continue

to monitor.
- At a later time – Registered Practical Nurse (RPN) was called to assist with resident #001; resident presenting distressed and stating having discomfort. Resident stating he/she was seeing people that weren’t there, and stated to nurse that he/she was feeling anxious.
- At a later time – Registered Nurse (RN) #014 indicated being called to resident #001’s room. Resident assessed as being anxious, complained of feeling sick, having shortness of breath and wanting to go to hospital. Resident has had GI symptoms most of day. Nurse administered routine medication and a PRN (as needed) anti-emetic. Report given by RN #014 to oncoming registered nursing staff, advising nursing staff to closely monitor resident.

Registered Nurse #014, who was the Charge Nurse on duty the identified date, indicated (to the inspector, January 13, 2017) awareness that resident had a designated SDM and that the Advanced Directives, signed and dated by SDM, directed to transfer resident to an acute care hospital should there be a serious deterioration in resident’s health condition.

RN #014 indicated that, he/she and Manager of Resident Quality, had explained to resident #001 that registered nursing staff were monitoring his/her symptoms, and indicated further that resident #001 had decided to remain at the long-term care home. Registered Nurse #014, again, indicated (to the inspector) being aware that resident #001 has a designated SDM for care (and financial) decisions. Registered Nurse #014 indicated that the SDM had not been contacted, on the identified date, regarding resident's change in health conditions.

Resident #002 was transferred to hospital the next day and was admitted. Resident underwent surgical intervention, was admitted to a specialized unit and subsequently transferred to another hospital.

Substitute Decision Maker indicated (to the inspector, on January 09, 2017) it is his/her belief that resident should have been sent to the hospital sooner, as per his/her prior direction. [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 there is a process in place and monitored, ensuring that the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care; and to ensure the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, the time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any responses were provided to the complainant and a description of the response, and any response made by the complainant.

Substitute Decision Maker (SDM) #002 indicated (to the inspector, on January 09, 2017) that he/she voiced concerns relating to the care and assessments, of resident #001, who was hospitalized on an identified date. SDM indicated concerns were voiced to registered nursing staff and Resident Service Coordinator.

The Administrator provided the Complaints Log binder, to the inspector on January 10, 2017, the binder contained two complaints, one dated for February 2016 and the other for March 2016, and neither complaints were related to resident #001.

The Administrator indicated (to the inspector, on January 11, 2017) that there would have been more than the two concerns and or complaints for 2016, but that she does not formally document concerns brought forward. Administrator indicated that often she jots down notes in her notebook when families or residents bring concerns to her attention and deals with concerns at the time that they arise, but that any documentation would not detail action taken, related dates for action or follow-up and or responses to or from the complainants.

Administrator indicated that she would gather together information pertaining to all 2016 concerns and or complaints and provide such to the inspector. At the conclusion, of this inspection, information requested by the inspector was not provided by the Administrator.

Administrator indicated that she did not recall if there were any concerns brought to her attention, specific to resident #001. [s. 101. (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 there is a documented record of all verbal and written complaints, ensuring that such includes, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, the time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any responses were provided to the complainant and a description of the response, and any response made by the complainant, to be implemented voluntarily.

WN #3: 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 failed to ensure that 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, that such is complied with.

- Under LTCHA, 2007, s. 21 - Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

- Under O. Reg. 79/10, s. 79/10, s. 100 - Every licensee of a long-term care home shall

ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101.

- Under O. Reg. 79/10, s. 101 (1) - Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. 2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. 3. A response shall be made to the person who made the complaint, indicating, what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief.

- Under O. Reg. 79/10, s. 101 (2) - The licensee shall ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

The licensee's policy, Complaints Procedure (#AM-6.1) directs the following:

- Every complaint made related to the care of a resident or the operation of the home shall be investigated in a timely, thorough and impartial manner. In the event that complaint alleges harm or potential harm to a resident, an investigation shall begin immediately.
- Any complaint given to a staff member, whether verbal or written, shall be directed or communicated immediately to the Administrator of the home.
- It is the responsibility of all staff to communicate verbal and written complaints to the Administrator or designate at the time they are received.

Substitute Decision Maker (SDM) #002 indicated (on January 09, 2017, to the inspector)

voicing concerns related to the care of resident #001. SDM indicated he/she voiced concerns to registered nursing staff and the Resident Service Coordinator (RSC) on more than one occasion. SDM was unable to recall exact dates, but indicated he/she voiced concerns that resident #001 should have been transferred to the hospital sooner.

Resident Service Coordinator indicated (to the inspector, on January 11, 2017) that he/she had received a phone call from SDM #002, regarding the care of resident #001. Resident Service Coordinator indicated that SDM #002 voiced concerns that resident #001 should have been transferred to hospital for assessment and treatment sooner than he/she had been. Resident Service Coordinator indicated that he/she had not documented the concern and, did not recall the date the concern was communicated to him/her by the SDM.

Resident Service Coordinator indicated that he/she had not communicated the concern, of SDM #002, to Administrator and or Director of Care. [s. 8. (1) (b)]

Issued on this 21st day of March, 2017

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

Original report signed by the inspector.