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 # / No de registre	Type of Inspection / Genre d'inspection
Feb 6, 2018	2017_643111_0022	022654-17, 025968-17	Critical Incident System

Licensee/Titulaire de permis

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

LYNDA BROWN (111)

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): December 18 -20, 2017

Two critical incident reports related to falls with injury resulting in transfer to hospital (Log # 022654-17 & 025968-17).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurse (RN),Personal Support Workers (PSWs), Physiotherapy Assistant (PTA) and Physiotherapist (PT).

During the course of the inspection, the inspector observed a resident and reviewed the health record of two residents (one deceased).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 :

The licensee failed to ensure the resident was reassessed, the plan of care reviewed and revised when the resident's care needs changed.

Related to log # 022654-17:

Review of the progress notes for resident #002 indicated on a specified date in 2017, the resident had a significant change in condition as follows: at a specified time, the resident reported the significant change in condition to RPN #103 and the resident was assessed with altered vital signs. The same RPN documented the staff also required the use of a mechanical lift for transfers due to concern with safety. There was no documented evidence the physician or the Substitute Decision Maker (SDM) were contacted regarding the significant change in condition. Approximately eight hours later, RPN #104 assessed the resident and noted the resident had visible signs of significant change in condition. RPN #104 reported the change in condition to the SDM and physician and the resident was sent to hospital for assessment where the significant change in condition was confirmed.

Interview with the DOC by Inspector #111, indicated that she had identified concerns related to the staff response to resident #002 significant change in condition and completed an investigation regarding the incident. The DOC indicated the resident's SDM and the physician were not immediately notified to determine actions to be taken until the following shift.

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Related to log # 025968-17:

A critical incident report (CIR) was submitted to the Director on a specified date in 2017, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in condition. The CIR indicated on a specified date and time, resident #001 was being transferred with a specified mechanical device by two PSW's (PSW #105 & #106) when the resident’s physical ability changed, and the resident subsequently fell. The resident was transferred to hospital and diagnosed with an injury to a specified area.

Interview with PT indicated resident #001 was assessed for a two person assist with use of a specified mechanical device and was appropriate for transfer at the time of the incident. The PT indicated the resident was unpredictable at times related to responsive behaviours. The PT indicated the resident also had previous symptoms that would also contribute to unpredictable level of physical ability. The PT indicated every resident should be re-assessed at each transfer to determine if level of transfer is appropriate.

Review of the progress notes over a three month period in 2017 for resident #001 indicated: the resident was a high risk for falls; had sustained eight falls all while attempting to self-transfer; and had one near miss fall. The resident was reassessed by the Physiotherapy Assistant (PTA) on three separate dates during the same time period and indicated the resident remained high risk for falls due to self- transferring and a two person assist with transfers. The progress notes also indicated the resident's health began to decline and level of mobility in the third month. The resident subsequently died twelve days after the last fall.

Review of the written plan of care for resident #001 (in place at time of the fall) indicated the resident was a two person extensive assistance with transferring due to potential for decline in physical abilities. There were two interventions identified but did not include the use of a mechanical device.

The plan of care was reviewed but not revised related to the level of transfer assistance required, when the resident's care needs changed. The resident had sustained eight falls over a three month period, was unpredictable, the type of mechanical device was not identified under transferring in the written plan of care, and the type of device to be used was inconsistently used.

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 revised when any resident's care needs change, specifically, has a change in condition, to be implemented voluntarily.

Issued on this 6th day of February, 2018

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

Original report signed by the inspector.