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

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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
Jun 25, 2018	2018_603194_0010	005354-18	Resident Quality Inspection

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

CHANTAL LAFRENIERE (194), JULIET MANDERSON-GRAY (607), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): April 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26 & 27, 2018

The inspectors also inspected a follow up log #001694-18 related to Compliance Order #001 for Registered staffing in the home, complaint logs #005501-18 related to resident care and staffing, and #006641-18 related to billing of unfunded services, critical incident logs #008115-18 and #007619-18 related to allegations of staff to resident abuse and #008116-18 for allegations of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Registered Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), RAI Coordinator, Life Enrichment Aide (LEA), Nutritional Manager, Dietary Aide (DA), Environmental Service Manager (ESM), Resident Services Coordinator (RSC), Manager of Resident Quality (MRQ), Resident Council President, Family Council Representative, Residents and Families.

The inspector toured the building, observed infection control practices, medication administration, meal services and provision of staff to resident care. The inspectors reviewed clinical health records for identified residents, documentation related to responsive behaviours, Registered staffing schedules, Family and Resident Council Minutes, Financial records related to unfunded services, staff educational records as well as relevant policies.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

- **15 WN(s)**
- **8 VPC(s)**
- **1 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1)

Related to log #001694-18

A Compliance Order #001 was issued for LTCHA 2007, s.8(3) Registered Nursing in the home, under inspection report #2017_643111_0023 with a compliance date of January 19, 2018.

The home is licensed for 124 beds, and qualifies for the exemption in O. Reg 79/10 s. 45(1)2.i
In the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used.

During interview with inspector #194 the Administrator verified that there were no planned or extended leave related to RN coverage at the home for the three and a half month review period.

Inspector #194 and the Administrator reviewed the RN schedule for the identified three and a half month period and verified that thirteen eight hour shifts did not have a RN who is an employee of the home and a member of the regular nursing staff present and on duty at the home. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

Related to log # 008116

A Critical Incident Report (CIR) was submitted to the Director for a resident to resident abuse involving resident #044 and #045. The CIR reported an injury to resident #045 and the initiation of 1:1 monitoring for resident #044 as a result of the abuse.

During an interview with inspector #194 on an identified date, DOC verified that the plan of care for resident #044 was updated to included the 1:1 monitoring to be started the day following the altercation. The DOC indicated that the 1:1 monitoring for resident #044 was implemented for the Days and Evening shift when the resident was awake. The DOC confirmed that 1:1 was not provided as implemented for resident #044 two identified dates.

During an interview with inspector #194 on an identified date, PSW #118 confirmed that there was no provision of 1:1 monitoring for resident #044 as implemented on two identified dates. PSW #118 indicated that documentation for staff responsible for 1:1 monitoring was completed on a paper form "security check flow sheet".

Review of the "security check flow sheets" for resident #044, for the period of 6 days was completed by inspector #194. The Security check flow sheets indicated that on an identified date no documentation was completed for the period of four hours, the following day no documentation was completed for the period of six hours, the following day no documentation was completed for the period of seven hours. The dates identified

with no documentation, were the dates that PSW #118 and DOC confirmed that 1:1 monitoring was not provided for resident #044.

The licensee failed to provide the care set out in the plan of care for resident #044 related to 1:1 monitoring was not provided on three consecutive days, as specified as in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the following are documented:
1. The provision of care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the care set out in the plan of care.

This inspection was initiated as a result of a triggered item during RQI inspection. During an interview with Inspector #623, resident #030 indicated that they are supposed to be bathed on two identified days, but this has not always happened.

A review of resident #030's clinical records for one and a half month period, was completed, which included the current plan of care, and POC documentation for all activities of daily living (ADL's). When reviewing the POC documentation for resident #030, the following gaps were identified;

Documentation was not completed for all areas of ADL's on the following shifts:
Days – five identified dates.
Evenings - 22 identified dates
Nights – four identified dates.

The scope was expanded to include resident's #021 and #029 and the following gaps in the POC documentation for a one month period, were also identified:

Resident #021
Days – 15 identified dates
Evenings – 20 identified dates
Nights – 18 identified dates.

Resident #029
Days – 29 identified dates
Evenings – 18 identified dates

Nights – 18 identified dates

During separate interviews with Inspector #623, PSW #113 and #114 both indicated that the expectation of the home is that when care is provided to residents, it is documented in the POC. This includes all ADL's, behaviours and meal intake.

During an interview with Inspector #623, RPN #103 indicated that the missing documentation is identified when the RAI/MDS is being completed, as well as during the daily bath sheet audits. RPN #103 indicated that this information is given to the DOC for follow up.

During an interview with Inspector #623, the DOC indicated that it has been identified that documentation is an issue in the home. The DOC indicated that the expectation is, all care that is given will be documented in POC by the PSW's, and registered staff will document in the electronic progress notes. The DOC indicated that at the monthly PSW staff meeting minutes, documentation requirements are always discussed. The DOC and Inspector #623 reviewed the meeting minutes for a four month period, which indicated that the documentation requirements were discussed and recorded in the minutes, including documentation of all care; baths, ADL's and meal intake. The DOC indicated that though the deficiency was identified as a problem, there is no formal monitoring or audit in place to ensure that documentation is completed.

The licensee failed to ensure that the provision of care set out in the plan of care for resident's #021, #029 and #030 was documented. [s. 6. (9) 1.]

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 by ensuring that the care set out in the plan of care is provided as set out in the plan and documented, 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with;

1. The licensee has failed to comply with the contracted pharmacy Medical Pharmacies policy 3-12 – (related to administration of a high risk medication)– as part of the medication management program under O.Reg. 79/10, s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Policy #3-12 (related to administration of a high risk medication) last reviewed February 2017.

Policy: To provide safe and accurate administration of (high risk medication).

Procedure:
12. Select preferred administration location on resident (abdomen, back or arms, upper legs, lower back)
18. Document administration location in MAR/eMAR. .

1. During the medication pass observation by Inspector #623, during the RQI inspection the following observation was made;

Inspector #623 observed RPN #117 administer oral and high risk medications to resident #048.

Review of the electronic medication administration records (eMAR) , for resident #048, did not identify the location of administration for high risk medication.

During an interview with Inspector #623, RPN #117 indicated being aware that the administration location for the high risk medication, selected for resident #048 was not best practice.

During an interview with Inspector #623, the DOC indicated that there is a Medical Pharmacies policy specific to the administration high risk medication, indicating the administration locations with direction to documentation of the locations in the e-MAR. The DOC indicated that the administration location, selected by RPN #117 was not a preferred administration location.

The licensee failed to ensure that the policy 3-12 (related to administration of high risk medication) steps, 12; Select preferred administration location on resident (abdomen, back or arms, upper legs, lower back) and 18; Document administration location in MAR/eMAR were complied with.

2. During the RQI inspection a review of the medication incidents was completed for the period of time for a three month period. The following high risk medication incident was selected for further inspection:

On an identified date it was discovered by RPN #127, that resident #048 had a change in medication orders. Nineteen days later, the incorrect medication was discovered in the medication cart. The newly ordered medication as well as previously discontinued medication were discovered within a medication storage area.

Review of the documentation in resident #048's progress notes indicated the following:

On an identified date, RPN #127 documented; when ordering the new medication it was noted that resident #048 had packages of both the newly ordered and previously discontinued medication available in the storage area and the medication cart contained resident #048's recently discontinued medication. There was no change of direction sticker on the label to identify that the medication order had changed.

On an identified date, RPN #117 documented that double step check for high risk

medication was completed, first check was prior to start of med pass, and second check was completed with medication administration. RPN #128 also documented that the evening high risk medication was checked by an RPN.

Review of the physician orders for resident #048 identified the following:
On an identified date, resident #48's high risk medication order was changed, with first check being completed by RPN #112 the following day and second check being completed by RPN #128 sixteen days later.

On an identified date, during an interview with Inspector #623, RPN #117 indicated that they were aware of the process for checking the medication against the MAR to ensure that the correct medication is being given.

During an interview with Inspector #623, the DOC indicated becoming aware of the medication incident related to high risk medication for resident #048 when the incident report was completed. The DOC indicated that the expectation is all high risk medication orders will be double checked prior to administration.

The licensee failed to ensure that the policy 3-12 (related to administration of high risk medication), was followed related to steps 2, 8, 10 and 11 of the Medication Administration policy that clearly identify the required checks which include an independent double check from another health care colleague or perform another separate task and come back to recheck steps 11. a-e before administering.

Resident #48's high risk medication was not administered in a preferred location, medication label for the drug did not reflect the change in physician ordered and dose was not double checked before being administered. [s. 8. (1) (b)]

2. The licensee has failed to comply with Medical Pharmacies policy #8-3 Transcribing Prescriber's Orders to eMAR/MAR sheet, as required under O.Reg. 79/10, s. 127. - Every licensee of a long-term care home shall ensure that a policy is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern changes in the administration of a drug due to modifications of directions for use made by a prescriber, including temporary discontinuation.

Policy #8-3 Transcribing Prescriber's Orders to eMAR/MAR Sheet (last reviewed August 2017)

Policy:
- All prescriber's orders are transcribed accurately and completely to the MAR or TAR sheet.
- Only a nurse may process a prescriber's order.
3. Changing Orders
Any CHANGE e.g. dose, direction, strength in medication order is considered to be a NEW order.
a) Discontinue existing order.
b) Add the new order to the MAR.
c) Change hours of administration, if applicable.
d) Notify pharmacy if the transcribed order does not match the original source of medical information.
It is the responsibility of the nurse transcribing the changed order to order a new supply of medication if needed or remove surplus medication from storage areas. Apply "Directions Changed" sticker to all medication containers which will continue to be used.

On an identified date it was discovered by RPN #127, that resident #048 had a change in medication orders. Eighteen days later it was discovered the discontinued medication was in the medication cart for resident #048 and that both the newly ordered and discontinued drugs were available in a storage area.

A review of the original physician's order that was written on an identified date, with first check being completed by RPN #112 the following day and second check being completed by RPN #128 sixteen days later.

RPN #112 and #128 were not available for interview during this inspection.

During an interview with Inspector #623, RPN #125 indicated that both RPN #125 and #127 are responsible to assist with the processing of new orders. RPN #125 indicated that when a new order for medication is processed, the nurse completing the first check would remove the old medication from all areas and place the old medication in the specified location for destruction. The nurse that completes the second check is to verify that all steps were taken when the order was processed.

During an interview with Inspector #623, the DOC indicated that an medication incident was discovered eighteen days after the medication was discontinued and was not removed from the medication storage area, therefore leaving it accessible for use. Both

types of medications were discovered in the medication storage areas, and had been used by registered staff since the medication was discontinued. The DOC indicated that when a medication order is written, it will be first and second checked as processed within 24 hours. Processing orders includes the RN or RPN documenting the changes, removing medications that have been discontinued and placing change of direction stickers for the medications that had a change in the direction for use, as well as notifying the SDM of the new orders and updating the care plan if required.

The licensee failed to ensure that Medical Pharmacies policy #8-3 Transcribing Prescriber's Orders to eMAR/MAR Sheet was complied with, resulting in discontinued medications being left accessible, resulting in resident #048 receiving medication that was no longer prescribed. [s. 8. (1) (b)]

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 by ensuring that the medication policies in the home are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system available in every area accessible by residents.

During the initial tour of the home, inspector #194 noted that there was a designated smoking area for residents, located at an identified location of the home. The smoking area is accessed through the key pad located at the door, the area is enclosed, gated and locked. The designated smoking area was not equipped with a resident-staff communication and response system.

During the initial tour of the home, two residents were observed by the inspector #194 to be smoking in the area. Resident #011 and #043 were observed by inspector #194 out in the smoking area and indicated having access to the coded smoking area. During interview with inspector#194, resident #012 also indicated having access to the coded smoking area at the home.

During interview with inspector #194, ESM verified that the smoking area did not have a resident-staff communication and response system available.

The licensee failed to ensure that a resident-staff communication response system was available for residents who access the outdoor smoking area. [s. 17. (1) (e)]

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 by ensuring that the resident-staff communication and response system available in every area accessible by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Definition on neglect
For the purpose of the Act and this Regulation
"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Related to Log #008115

A Critical Incident Report (CI) was submitted to the Director for an allegation of neglect affecting eight residents.. The CI indicated that residents #050, #051, #052, #053, #054,#013, #017and #018 were found to be in need of personal care by the oncoming shift.

Review of the internal investigation statements and interview by inspector #194, indicated that PSW #108 and #122 found eight residents requiring personal care upon start of the shift with outcomes of the investigation confirming that the allegations were founded.

Review of the internal investigation statements by PSW #120 and #121 were completed by inspector #194, neither PSW's were available for interview during the inspection.

The plan of care for resident #050 indicated that two staff assist was required for care and that an alarm device was to be in place while in bed for safety. Review of PSW #120's statement indicated that no assistance was provided by PSW #121 for the care of resident #050 during the identified period. Review of PSW #121 statement indicated that resident #050 was provided care and alarm device was attached. Review of statements from PSW #108 and #124 indicated that resident #050 was found to be in bed without

alarm device. During interview, PSW# 108 confirmed the information documented during the investigation by the home.

The plan of care for resident #051 indicated that two staff assist was required for care. Point of care documentation complete by PSW #120 indicated that resident #051 was provided a toileting aid at an identified time. Review of PSW #121 statement indicated not being aware that resident was on a toileting aid. Statements and interviews with PSW #108 and PSW #122 confirmed that resident #051 was found on a toileting aid, at the beginning of the shift. During an interview with inspector #194 resident #052 was able to recall the incident of being assisted on a toileting aid, stating that a call to staff must have been made but was unable to indicate the staff, time of day or length of time the resident was on the toileting aid.

The plan of care for resident #052 indicated two staff assist was required for care. Review of PSW #120's statement indicated that resident #052 was provided care, was assessed to have a change in condition and charge nurse was notified. Review of statements and interview of PSW #108 and PSW #122 indicated that resident #052 was found in need of care at the beginning of the shift.

Resident #053 plan of care indicated one staff assist for care and staff are to offer toileting aid. PSW# 120's statement indicated that resident #053's toileting aid was provided earlier on in the shift. Review of statements and interview with PSW# 108 and #122 indicated that resident #053 was found with a toileting aid in need of continence care at beginning of the shift. During interview with inspector #194, resident #053 indicated remembering the incident, but stated not being aware of any concerns.

The plan of care for resident #054 indicated that two staff assistance was required for care. Review of the statement for PSW# 120 and PSW #121 indicated that no assistance was provided to resident #054. Review of statements and interview with PSW #108 and #122 indicated that resident #054 was found in need of care at beginning of shift.

The plan of care for resident #013 indicated that prompting was required related to continence care at a specific time. Review of the PSW #120 and #121 statements indicated that no care was provided for resident #013 at the specific time noted in the plan of care. Review of the statements and interview with PSW #108 and #122 indicated that resident #013 was found to be in need of continence care at the beginning of the shift.

The plan of care for resident #017 indicated that a toileting aid was to be provided at a specific time. Review of the statement for PSW #120 indicated that no toileting aid was provided at the specific time noted in the plan of care. Review of the statements and interviews with PSW #108 and #122 indicated that resident #017 was found to be in need of continence care at the beginning of the shift.

The plan of care for resident #018 indicated two staff assist with continence care at a specific time. Review of the statement for PSW #120 indicated that no assistance with continence care was provided to resident #018, during the specific time noted in the plan of care. Review of the statement for PSW #121 indicated that continence care was provided. Review of the statement from PSW# 108 and #122 indicated that resident #018 was noted to be in need of continence care at the beginning of the shift.

The licensee failed to protect residents and ensure that residents were not neglected, when care was not completed by PSW #120 and #121 for the identified residents as required in the plans of care. [s. 19. (1)]

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 by ensuring the home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan:
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work? (including 24/7 RN coverage)
(e) get evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During an interview with Inspector #623, the DOC provided a copy of the Nursing Department Assignment Sheets as well as an Interoffice Memo dated January 14, 2015 - Call-ins. The identified documents did not provide for a written back-up staffing plan in the event that staff could not come to work and a shift could not be covered. The DOC was unaware if there was a written backup staffing plan for the home. The DOC was also unaware of an annual evaluation of the back-up staffing plan for nursing and personal care staffing.

During an interview the Administrator indicated that there was no formal written back-up plan for nursing and personal care staffing of the home in the event of a staff member could not come to work and a shift could not be covered. The Administrator indicated that the staff and Managers are all aware of the protocol to follow and there was no formal written process. The Administrator also indicated that the staffing plan is reviewed frequently and changes are made to align with the resident needs, but is not formally reviewed annually.

The licensee failed to ensure that written a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work was available and that the plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 31. (3)]

2. The licensee has failed to ensure that there a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During an interview with Inspector #623, the Administrator indicated that the staffing plan for nursing and personal support services is reviewed frequently and changes are made to align with the resident needs, but there is no written record of each evaluation, including the annual evaluation of the staffing plan.

The licensee has failed to ensure that there is a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 31. (4)]

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 by ensure that there is a written back up plan for staff and that the plan is updated and at a minimum annually evaluated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed, a minimum, twice weekly by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

This inspection was initiated as a result of the RQI inspection. During an interview with Inspector #623, resident #030 indicated that they are supposed to be bathed on two specific days, but this has not always happened. Instead of a tub bath, resident #030 indicated that they receive a bed bath, and this does not include washing their hair. Resident #030 indicated that this happens quite often unless they are very insistent. Resident #030 indicated that they might get in the tub once a week, and they want two baths a week.

Review of resident #030's clinical records, including the current plan of care related to bathing, POC documentation related to bathing and progress notes for a two month period was completed. After reviewing this it was identified that resident #030 is scheduled for baths on a specific shifts.

The plan of care for bathing and shampooing indicated the following:
Bathing: extensive assistance from two staff to complete bathing.
Interventions: Two staff to transfer resident into bathtub using the mechanical lift. Ensuring they are providing resident with step by step instructions of what they are doing for the resident.
- resident is to receive a bath twice weekly as per bathing schedule.

Review of resident #030's Point of Care (POC) flow sheet documentation records for baths for a one and a half month period, was completed.The POC does not identify what type of bath is provided, it only indicates that a bath was completed, the number of staff required and the type of assistance required. During the identified period there was one bath refused, one did not occur and four baths were not documented.

Review of the progress notes for resident #030 indicated that there is no documentation to identify that resident #030 refused or did not receive a bath on six identified dates.

Review of the bath audit sheets that were completed daily by the RAI Coordinator and submitted to the DOC, indicated that resident #030's baths were not done, refused or no evidence documentation in POC.

The scope of inspection was then expanded by the Inspector to include resident #021 and #029.

During an interview with Inspector #623, resident #029 indicated that they cannot remember the last time that they had a bath or a shower. Resident indicated that they prefer a shower and their hair is washed twice weekly.

Review of resident #029's clinical records including the current plan of care related to bathing, POC documentation related to bathing and progress notes for a two month period. It was identified that resident #029 is scheduled to be bathed on two specified shifts.

The plan of care for bathing and shampooing indicated specific interventions based on the resident's care needs.

Review of resident #029 POC flow sheet documentation for one and a half month period related to baths, indicated seven baths were not documented and three did not occur and two baths were refused.

Review of the progress notes for resident #029 indicated that there is no documentation to identify that resident #029 refused or did not receive a bath on the twelve identified dates.

Review of the bath audit sheets that are completed daily by the RAI Coordinator and submitted to the DOC, indicated that the above dates are identified for resident #029 as bath not done, bath refused or no documentation in POC.

There is only one bath documented as completed in the identified period for resident #029. It is unclear if the resident has received a bath during this time.

During an interview with Inspector #623, resident #021 indicated that they receive a bath but not always twice a week. Resident #021 indicated that their preference is a tub bath, and when a bath is given their hair is washed. Resident #021 indicated that they could not recall ever receiving a bed bath, but they have been told that they would not receive a bath at all on a day that their bath was scheduled to be completed.

Review of resident #021's clinical records including the current plan of care related to bathing, POC documentation related to bathing and progress notes for a two month period, was completed. It was identified that resident #021 is scheduled to be bathed on two identified shifts.

The plan of care for bathing and shampooing indicated the following:
Bathing: extensive assistance from two staff members for bathing as per schedule.
Interventions: Resident #021 prefers a tub bath for all bathing. Two staff to transfer resident onto the tub chair lift, one to operate the lift while the second staff guides the resident into the tub. Once safely in the tub, one staff to provide resident with a washcloth and verbally cue to begin washing their trunk. If at any time resident is unable to complete a task, staff is to complete it. Staff to provide all other aspects of bathing. Once bathing is completed, staff to ring for assistance with transfer out of the bathtub.

Review of resident #021 POC flow sheet documentation for one and half month period related to bathing, indicated one bath was refused and two did not occur.

Review of the progress notes for resident #021 indicated that there is no documentation to identify that resident #021 refused or did not receive a bath on the three identified dates.

Review of the bath audit sheets that are completed daily by the RAI Coordinator and submitted to the DOC, indicated that the above dates are identified for resident #021 as bath not done or bath refused.

During an interview with Inspector #623, PSW #113 indicated that resident's will receive all care that is required which could include a scheduled bath. PSW indicated that every effort is made to give the resident a bath or shower according to their preference. On occasion a bed bath is offered in place of a tub bath or shower. PSW #113 indicated that when a bed bath is given, the resident's hair is not always washed. PSW#113 indicated that there are dry shampoo cap available to wash resident's hair with but the PSW does not usually use them. PSW #113 indicated that if a bed bath is given, this is documented as a bath being completed. PSW #113 indicated that if a resident refuses a bath or a bath is not given when it was scheduled, the PSW documents in POC as "refused" or "88" did not occur. The PSW is to report to the RPN so that documentation can be completed in the progress notes to indicate that the bath was missed and the reason why.

During an interview with Inspector #623, PSW #114 indicated that when a resident is scheduled for a bath, they usually receive a tub bath or a shower according to their preference. PSW indicated that on occasion a bed bath will be give but not very often does this happen. PSW #114 indicated that when a bed bath is given, a resident can have their hair washed using a dry shampoo cap and these are readily available if required. PSW #114 indicated that if care is not provided to a resident for any reason, refused or unable, then the PSW is required to document in POC that care was refused or "88" activity did not occur. The PSW is then required to report to the RPN to document in the progress notes that the care did not occur and the reason why. PSW #114 indicated that resident #030 never refuses to be bathed and prefers a tub bath, resident #029 will occasionally resist to be bathed, prefers a shower and RPN #101 will assist to get the resident in the shower. PSW #114 indicated that they are not familiar with resident #021's preferences.

During separate interviews RPN #101, RPN #112, RPN #104 indicated that all care will be provided for all residents as identified in the plan of care, including any scheduled baths. The PSW is to document the care that was provided to all resident's in their assignment, in POC. RPN #101 indicated that if a resident refuses care or if care cannot be completed for any reason, the PSW is to document in the POC that the care did not happen or that the care was refused. The PSW's are then to report to the RPN, who

complete documentation in the progress notes. RPN #101, #112 and #104 all indicated that they feel baths are being given as scheduled on most days, they have not been made aware of resident's not receiving baths.

During an interview with Inspector #623, RPN #103 indicated that missing documentation is identified when the bath sheet audits are completed daily. RPN #103 indicated that this audit is given to the DOC for follow up.

During an interview with Inspector #623, the Director of Care (DOC) indicated that resident's are to be provided with two baths a week and that a bed bath could be completed in place of a shower or a tub bath. The DOC indicated that daily, the RAI Coordinator completes a bath sheet audit that identifies resident's scheduled for a bath and indicates if the bath was completed, refused, not given or not documented. The DOC indicated that when deficiencies are identified in the audit, the PSW staff responsible for the bath is followed up with by the DOC. The DOC indicated that the bath audit sheets were historically not reviewed for omissions, refusals or baths not given. The DOC indicated that when a resident refuses care or care is not provided, the documentation in POC should reflect this. The PSW is also to report this to the RPN and a progress note should be written to reflect the reason for the care not being given.

The licensee has failed to ensure that the resident is bathed, at minimum, twice weekly by the method of his or her choice, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. During interviews, resident's #021, #029 and #030 indicated that they were not always receiving two baths a week and were not always being bathed by the method of their choice. Clinical records reviewed over a six week period identified six occasions where baths were documented as not provided and eleven occasions where documentation was incomplete and it could not be determined if resident's #021, #029 and #030 received a scheduled bath. [s. 33. (1)]

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 by ensuring that the resident is bathed, at minimum, twice weekly by the method of his or her choice, including tub baths, showers and full body sponge baths, and more frequently as determined by the resident's hygiene requirements., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident.

During stage 2 of the RQI inspection, a review of the medication incidents recorded for a three month period was completed. Three high risk incidents were selected for further review.

On an identified date, a medication incident occurred involving resident #046. The

incident details describe the following:
RPN #117 was providing medical intervention to a co-resident. RPN #117 placed down a medicine cup of medication in order to be able to administer a high risk medication to the co-resident. While RPN #117 was administering the high risk medication, resident #046 grabbed the medicine cup and took the medications.

Review of the progress notes for resident #046 on identified date indicated the following: While RPN #117 was administering medication to co-resident, resident #046 mistakenly took pills that were not for the resident.

During an interview with Inspector #623, RPN #117 indicated that a medication incident did occur, involving resident #046 ingesting resident #049's medications in error. During an interview, RPN #117 indicated that the medication incident occurred when the medications for resident #049 were set down, while another medical intervention was provided for resident #049's. RPN #117 had their back to resident #046 who was also in the area, and did not see resident #046 reach for the medications and ingest them, until they had already swallowed them.

The licensee failed to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident, when resident #046 received medications that were prescribed for resident #049 in error. [s. 131. (1)]

2. As part of the mandatory home IP, a review of medication incidents was completed and the following was identified:

On an identified date, RPN #127 discovered that resident #048 had packages of two types of a high risk medication in the storage area. It was also noted that resident #048's discontinued high risk medication was in use. RPN #127 reviewed the current orders of the high risk medication for resident #048 which indicated that on an identified date, a new order was initiated and the previous order for the high risk medication had been discontinued.

Review of the physician orders for resident #048 indicated that on an identified date, the physician wrote an new order for the high risk medication.

First check of the order was completed by RPN #112 the following day. A second check was not completed until sixteen days later, by RPN #128.

Review of the electronic medication administration records (eMAR) identified that the new orders for the new high risk medication for resident #048, were initiated on day following the physicians orders.

During an interview with Inspector #623, RPN #117 indicated that they recall the medication incident involved resident #047 and a change in medication orders. RPN #117 indicated that they were aware of the process for checking medications to ensure that the right resident is receiving the right drug, right dose, right route and right time, when a medication is being given. RPN was unsure how this mistake happened.

During an interview with Inspector #623, the DOC indicated becoming aware of the medication incident related to resident #048 when the incident report was completed. The discontinued high risk medication was not removed from the medication cart and storage area, therefore leaving it accessible for use. Seventeen days later, both high risk medications were discovered in the medication cart and storage area and appeared to have been used by registered staff.

The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, when resident #048 received discontinued medication. [s. 131. (1)]

3. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of the medication incidents recorded for a three month period, was completed as part of the RQI inspection. Three high risk incidents were selected for further review, as a result, the following was identified:

On an identified date it was discovered by RN #119, during a shift change narcotic count, that resident #055 had received the incorrect dose of a medication. The incident report indicated that RN #119 had obtained the medication from resident #056's medication card which was a different dose. This incorrect card contained a higher dose of medication, as a result resident #055 received an incorrect does of medication than what was ordered.

Review of the progress notes for resident #055 indicated that upon discovery of the error, RN #119 contacted the physician for further directions. The progress notes indicated that the physician advised that the residents vital signs be monitored every four hours for a

period of time. Documentation indicated that this was completed. The progress notes also indicated that the SDM was notified of the incident and had no concerns.

During an interview with Inspector #623, RN #119 indicated that a medication incident was discovered at the change of shift when a narcotic count was being completed. Earlier in the day RN #119 had documented that they administered the medication to resident #055, RN #119 mistakenly used a medication card belonging to resident #056 that contained the same drug but a different dose. The RN indicated that the error occurred when the incorrect card was used to prepare the medication for administration. RN #119 indicated that at the time the medication was prepared, proper checks were not completed to ensure that the correct resident and the correct medications were administered.

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, when resident #055 received an incorrect amount of a medication than what was ordered. [s. 131. (2)]

4. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On an identified date, Inspector #623 observed RPN #117 during a medication pass. observation portion of the mandatory medication IP. The following was observed:

RPN #117 was observed by Inspector #623, crush all of the pills for resident #047 and then place the crushed pills and a liquid medication into a bowl of food. The RPN then gave the bowl of food that contained the medications, to PSW #113. PSW #113 then began to feed the food to the resident.

During an interview, Inspector #623 enquired if PSW #113 was permitted to administer medications. RPN #117 indicated that this is how medications are always given to resident #047. RPN #117 also indicated that staff #113 is a PSW and shouldn't give medications to residents.

During an interview PSW #113 indicated that when RPN #117 is working, resident #047 receives their medications in food. PSW #113 indicated that all other RPN's administer the medications to resident #047 in applesauce and the RPN does this themselves. PSW #113 indicated that they are not a registered nurse or registered practical nurse and that

they have not received training for administration of medications.

During an interview, the DOC indicated that they were unaware that RPN #117 was allowing the PSW's to administer medications to resident #047. The DOC indicated that medications are only administered by the registered nurse, registered practical nurse, a physician or a dentist.

The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, when RPN #117 permitted PSW #113 to administer medications to resident #047. [s. 131. (3)]

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 by ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident; that medications are administered as prescribed and administered to residents in accordance with directions for use specified by the prescriber; that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b)?

During the RQI inspection a review of the medication incidents was completed for the period of three months. Three high risk incidents were selected for further review.

1. On an identified date it was discovered during a shift change narcotic count that resident #055 had received an incorrect dose of medication. The incident report indicated that RN #119 had obtained the medication from another residents medication card. This incorrect card contained a different dose of medication, resulting in resident #055 receiving medications at an dose other than what was intended by the prescriber.

2. On an identified date RPN #117 was providing medical attention to a resident an placed down a medicine cup of medication. While RPN #117 was providing medical attention to a co-resident, resident #046 grabbed the cup and took the medications. This resulted in resident #046 receiving medications without an order.

3. On an identified date it was discovered by RPN #127, that resident #048 had a change in medication orders for a high risk medication, and sixteen days later, the discontinued high risk medication discovered in the medication cart, currently in use. Both the current and discontinued high risk medications were discovered in the medication storage area. This resulted in resident #048 receiving medication without an order.

A review of each medication incident report indicated that there was no review or corrective action identified on any of the reports.

During an interview with Inspector #623, RPN #117, was identified in two of the medication incident reports, did not recall meeting with the DOC or a designate following the discovery of the incidents.

During an interview with Inspector #623, RN #119 indicated that when the medication incident occurred involving resident #055 receiving the wrong dose of medication, there was no follow up or corrective action with the DOC or a designate. RN #119 indicated

that no one spoke to them regarding the circumstances surrounding the error.

During an interview with Inspector #623, the DOC indicated that there was no specific follow up with RN #119 related to the medication incident involving resident #055. The DOC indicated that at the time of discovery, RN #119 self reported and followed all of the steps as outlined in the medication incident reporting policy. The DOC indicated that there have been no trends identified with medication incidents.

During an interview with Inspector #623, the DOC indicated that they did not speak to any of the registered staff involved with the medication incident that occurred when resident #048 had a change in order for the high risk medication, and it was discovered sixteen days later, that the medication was not removed from the medication cart and storage area, therefore leaving it accessible for use. The DOC also indicated that they did not speak to RPN #117 as a follow-up to the medication incident report when resident #046 took another resident's medications.

The licensee failed to ensure that all medication incidents are documented, reviewed and analyzed, that corrective action is taken as necessary, and a written record is kept of everything. [s. 135. (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 by ensuring that all medication incidents are documented, reviewed and analyzed, that corrective action is taken as necessary, and a written record is kept of everything. , to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee ensured that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Related to Log #008115

Review of the licensee's "Zero tolerance of Abuse and Neglect of Residents" AM-6.9

Definition of neglect;
Neglect means the failure to provide a resident with the treatment, care, services or assistance required for the health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents.

- Any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Home's Administrator or appropriate designate.

-In cases where the staff member witnesses/suspects/ hears about an act of abuse or neglect, the first course of action shall be to ensure that the resident s is taken to a safe and secure environment. Once the resident is physically safe, the following steps shall be taken;
-report incident to direct manager, Director of Care or Administrator.

A Critical Incident report was submitted to the Director on an identified date to report Improper/Incompetent treatment of eight identified residents.

On an identified date and time, PSW #108 and PSW #121 discovered a number of residents for whom care had not been provided by the previous shift.

During interview with inspector #194 , PSW #108 indicated that after receiving report on an identified date, they commenced to provide care to the assigned residents. PSW #108 indicated that a number of residents were identified with continence care needs. PSW #108 indicated to inspector #194 reporting the neglect to resident to the MRQ after the required care for all identified residents was provided and assistance in the dining room was provided.

During interview with inspector #194, PSW # 122 also confirmed that on the identified day, when care was provided to assigned residents, it was noted that a number of residents were identified with continence care needs. PSW #122 indicated to inspector #194 that the neglect of care was not immediately report to management, that the reporting of the incident would be completed by PSW #108.

During interview with inspector #194, Manager of Resident Quality (MRQ) indicated that PSW #108 reported the allegations of neglect on an identified date and time and that the allegations of neglect were reported to the Administrator and Director of Care immediately.

The licensee failed to comply with it's Zero Tolerance of Abuse related to reporting when PSW #108 and PSW #122 did not immediately report the suspicion of neglect to the manager and when the Administrator did not immediately report the allegations of neglect to the Director. [s. 20. (1)]

WN #11: 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.

Related to Log #008115

A Critical Incident report was submitted to the Director on an identified date and time to report Improper/Incompetent treatment of eight identified residents, eight hours after being reported by staff.

During an interview with inspector #194 the Administrator indicated becoming aware of the incident on an identified date and time. Inspector #722 in the home during RQI inspection, was approached by the Administrator who reported the neglect of care which was reported by staff, eight hours earlier.

The licensee failed to ensure that 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: pertaining to improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. [s. 24. (1)

WN #12: 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 failed to ensure that advise received from the Residents' Council was responded in writing within 10 days of receiving the advise.

A record review indicated that an identified concerns directed to the Environmental Services Department was raised during the November 2017, Residents' Council meeting related to the laundry delivery service. The written response from the Administrator to Resident Council, in December 2017, indicated there was no concerns brought forward by Resident Council in November 2017.

During an interview the Environmental Services Manager (ESM) indicated that on April 17, 2018, that when there was a concern brought forward to the ESM manager, the ESM would follow-up and present the response to the Administrator either verbally or through email. The ESM indicated that the Administrator would then respond to Resident Council in writing.

During an interview, the Administrator indicated a response was made to the Resident Council in December, 2017, indicating there was no concerns brought forward and this was a mistake. The administrator indicated the response brought forward by Resident Council related to laundry services was not responded to.

The licensee failed to respond in writing within 10 days to the Resident Council related to laundry services concerns expressed in the December 2017 meeting. [s. 57. (2)]

WN #13: 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 in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

A record review indicated that an identified recommendation was raised during the March 2018, Family Council meeting related to residents with Cognitive impairments having more activities to participate in, as well as a concern related to residents personal items were often missing. There was no documented evidence to indicate that a written response from the Administrator related to the above identified concern and recommendation was forward to Family Council.

During an interview the President of Family Council indicated that a response was not received in writing from the long term Care home related to the above recommendation and concern.

During an interview the Administrator, indicated not responding in writing to Family Council related to the above identified concern and recommendation.

The licensee failed to respond in writing within 10 days to the Family Council, related to concerns expressed for increased activity for residents with Cognitive impairments and residents personal items going missing in the March 2018 meeting. [s. 60. (2)]

WN #14: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' and Family Council is sought in developing and carrying out the satisfaction survey.

During an interview the President of Resident Council, could not verify if the Long term Care home sought the advice of Resident Council in developing and carrying out the annual satisfaction survey.

An interview the Administrator revealed that the home uses a standardized survey, and Resident and Family Council were therefore not consulted in developing and carrying out the home's annual satisfaction survey.

The licensee failed to seek the advice of the Residents' and Family Council, in the development and carrying out of the satisfaction survey. [s. 85. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 261. Statements

Specifically failed to comply with the following:

s. 261. (1) Every licensee of a long-term care home shall, within 30 days after the end of each month, provide each resident or the resident's attorney under the Powers of Attorney Act, or person exercising a continuing power of attorney for property or a guardian of property under Part I of the Substitute Decisions Act, 1992, with an itemized statement of the charges made to the resident within the month. O. Reg. 79/10, s. 261 (1).

Findings/Faits saillants :

1. The licensee failed to, within 30 days after the end of each month, provide each resident or resident's attorney under the Powers of Attorney Act, or person exercising a continuing power of attorney for property or a guardian of property under Part I of the Substitute Decision Act, 1992, with an itemized statement of the charges made to the resident within the month.

Log #006641-18

A complaint was received by the Ministry of Health and Long Term care on an identified date, from SDM of an identified resident indicated having received a statement related to an outstanding amount for unfunded services for the period of twelve months.

During a telephone interview by inspector #194, SDM of an identified resident indicated that no monthly billing for the outstanding unfunded services for an identified resident had been received for the period of twelve months.

During Interview by inspector #194 with the Administrator and Office manager separately, it was verified that the invoices for the services were available in the homes computer software, but the home was unable to provide evidence that the monthly itemized invoices were provided to the SDM. The Administrator indicated during the interview with inspector #194 that no payment for unfunded services for the period of twelve months had been received by the SDM and that no written communication to the SDM could be provided related to the outstanding account. [s. 261. (1)]

Issued on this 11th day of September, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194), JULIET MANDERSON-GRAY (607), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2018_603194_0010
Log No. / No de registre :	005354-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 25, 2018
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
LTC Home / Foyer de SLD :	Riverview Manor Nursing Home 1155 Water Street, PETERBOROUGH, ON, K9H-3P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mary Anne Greco

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date (s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_643111_0023, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee will ensure that there at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement,

Grounds / Motifs :

1. A Compliance Order #001 was issued for LTCHA 2007, s.8(3) Registered Nursing in the home, under inspection report #2017_643111_0023 with a compliance date of January 19, 2018.

Related to log #001694-18

A Compliance Order #001 was issued for LTCHA 2007, s.8(3) Registered Nursing in the home, under inspection report #2017_643111_0023 with a compliance date of January 19, 2018.

The home is licensed for 124 beds, and qualifies for the exemption in O. Reg 79/10 s. 45(1)2.i
In the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used.

During interview with inspector #194 the Administrator verified that there were no planned or extended leave related to RN coverage at the home for the three and a half month review period.

Inspector #194 and the Administrator reviewed the RN schedule for the identified three and a half month period and verified that thirteen, eight hour shifts did not have a RN who is an employee of the home and a member of the regular nursing staff present and on duty at the home. [s. 8. (3)]

A Compliance Order will be reissued under O. Reg 79/10 s. 8(3) related to the homes compliance history . A Compliance Order for O. Reg 79/10, s.8(3) under inspection report #2017_643111_0023 was issued with a compliance date of January 19, 2018. A Compliance Order for O. Reg. 79/10 s.8(3), was issued under report #2016_280541_0032 in November 2016 , reissued in March 2017 under report # 2017_590554_0009 and complied in June 2017.

(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 25th day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
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Name of Inspector / Nom de l'inspecteur : Chantal Lafreniere

Service Area Office / Bureau régional de services : Central East Service Area Office