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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 31, 2019	2019_643111_0013	017190-18, 020349-18, 026391-18, 028040-18, 003698-19, 007746-19	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): April 23 to 25, 2019

The following complaints were inspected concurrently during this inspection:
-Log #003698-19 (CIR) related to unaccounted narcotics and staffing.
-Log #020349-18 (CIR) related to fall resulting in an injury, staffing and SDM notification.

The following critical incidents were inspected concurrently:
-Log #028040-18 (CIR) for alleged staff to resident abuse.
-Log #026391-18 (CIR) and Log #017190-18 (CIR) for a fall resulting in injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Scheduling Clerk, Physiotherapist (PT), Personal Support Workers (PSW), resident's families, Registered Nurses (RN) and Registered Practical Nurses (RPN).

During the course of the inspection, the inspector reviewed the health records of residents, reviewed nursing staff schedules, staff call-in records, complaints logs, multidisciplinary monthly falls meeting minutes and the home's investigation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure that when the resident was being reassessed and the plan of care was being revised, because care set out in the plan had not been effective, that different approaches had been considered in the revision of the plan of care.

A critical incident report (CIR) was submitted to the Director on a specified date, for a fall incident that caused an injury to a resident for which the resident was transferred to hospital. The CIR indicated on a specified date and time, resident #003 sustained a fall and complained of pain to a specified area. The resident was transferred to hospital and diagnosed with a specified injury.

Review of the progress notes for a specified period for resident #003, indicated the resident sustained a number of falls during that period as follows:
-On a specified date and time, the resident sustained a fall, after attempting to self-transfer for toileting needs and no injuries were sustained. There was no indication that a specified intervention was in place.
-On a specified date and time, the resident sustained a fall, after attempting to self-transfer for toileting needs and activating a specified intervention. No injuries were sustained. The following day, Physiotherapist (PT) assessed and indicated the resident had a specified falls prevention intervention in place, that the resident would remove and was at risk for falls.
-On a specified date and time, the resident sustained a fall and complained of pain to a specified area. The resident was attempting to self-transfer for toileting needs. No injuries were sustained.There was no indication that a specified intervention was in place.
-On a specified date and time, the resident sustained a fall, after attempting to reach for an object. The resident complained of pain to a specified area and sustained an injury to a specified area. There was no indication that a specified intervention was in place.
-On a specified date and time, the resident sustained a fall, after attempting to self-

transfer for toileting needs. The resident complained of pain to a specified area and had injuries to specified areas. There was no indication that a specified intervention was in place.
-On a specified date and time, the resident sustained a fall and complained of severe pain to a specified area. There was no indication that a specified intervention was in place. The resident was transferred to hospital for assessment, was diagnosed with an injury to a specified area and subsequently died.

Review of the written plan of care for resident #003 related to falls risk, indicated the resident was at risk for falls due to specified reasons. There were specified interventions identified. The care plan was reviewed on two other dates but no new interventions were considered.

During an interview with RPN #105, they indicated they were the Falls Prevention lead. The RPN indicated when a resident sustains a fall, the nursing staff were to assess the resident for injury, if injury, notify the physician and/or transfer to hospital for assessment. The RPN indicated if there was no injury, the resident was to be monitored for a specified period of time and the information documented. The RPN indicated they were also to complete specified post fall assessments, notify the physician and the SDM and complete a referral to PT. The RPN indicated they had monthly meetings with the Falls Prevention team (which included PT) where they reviewed all the falls that occurred in the month, complete the Falls Meeting Tracking Form which identified all the residents who sustained a fall and possible interventions/or changes in interventions if ineffective. The RPN indicated they also discussed any residents who sustained a fall and possible interventions, at the daily morning management meeting. The RPN indicated resident #003 was at risk for falls, used to have specified interventions but the resident would remove one specified intervention and self-transfer. The RPN indicated they usually updated any residents care plans related to falls risk. The RPN confirmed the care plan for resident #003 was not revised and other interventions considered when the resident continued to sustain falls, around toileting needs and despite having a specified intervention that the resident would remove and/or was not implemented by staff.

During an interview with the DOC, they indicated it was the responsibility of all nursing staff to update the resident's care plan whenever there is a change but it was usually the falls prevention lead that would update the residents care plans related to falls risk.

The licensee has failed to ensure that when resident #003 was being reassessed and the plan of care related to risk for falls was being revised, because care set out in the plan

had not been effective, that different approaches had been considered in the revision of the plan of care.

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 when a resident has fallen, the resident is reassessed and the plan of care is revised, when the care set out in the plan has not been effective and different approaches are considered, to be implemented voluntarily.

WN #2: 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 :

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

Two complaints were submitted to the Ministry of Health and Long-Term Care regarding concerns with the high number of agency nursing staff that were being used in the home.

Riverview Manor is a 124 bed long-term care home. Inspector #111 requested and received from the Administrator, the home's schedule of Registered Nurses who worked during a specified period. The home did not have an RN working in the building at all times on a number of specified dates/shifts.

Interview with the Scheduling Clerk confirmed there were no RNs documented as working on the specified dates/shifts identified.

Interview with the DOC confirmed there were permanent postings for RNs that had not yet been filled and the home attempted to fill the vacancies with use of agency RNs or the DOC would cover when able.

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 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 be implemented voluntarily.

Issued on this 6th day of June, 2019

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

Original report signed by the inspector.