Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Jan 6, 2022	2021_885601_0020	025787-20, 002787-21, 004325-21, 009629-21, 010431-21, 011950-21	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

KARYN WOOD (601)

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): November 5, 8, 9,10,12,15, and 16, 2021.

The following intakes were completed in this Critical Incident System (CIS) Inspection:

Four logs related to a fall that resulted in a significant change in a resident's condition.

A log related to concerns regarding medication administration.

A log related to allegations of improper care of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Care Coordinator (CCC), RPN/Manager of Resident Quality IPAC Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist, Personal Support Workers (PSW), Housekeeping Workers (HW), Public Health Inspector (PHI), and residents.

The inspector also reviewed resident health care records, internal investigations, applicable policies, observed infection control practices in the home, observed the delivery of resident care and services, including staff to resident interactions and medication administration.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Reporting and Complaints
Safe and Secure Home

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

7 WN(s)
6 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to the failure to maintain infection prevention and control measures specified in Directive #3 regarding maintaining two meters distance from others while on a break while not wearing a medical mask.

Physical distancing was not being maintained while staff were on a break outside of the home. Staff were observed to be within two meters of others with no medical procedure mask. The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. As per Directive #3 from July 16, 2021, all staff of long-term care homes must always remain two meters away from others and be physically distanced before removing their medical mask for eating and drinking.

The Peterborough Public Health Inspector and the Administrator confirmed the staff should be maintaining two meters distance from others while on a break and not wearing a mask, as per Directive #3. The lack of adherence to Directive #3 related physical distancing presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3 (version effective date July 16, 2021), observations throughout the home by Inspector #601 and interview with Peterborough Public Health Inspector. [s. 5.]

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 ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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 the medication policy in place under O. Reg. 79/10, s. 114 (1) when 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 was complied with.

The Ministry of Long-Term Care received a Critical Incident System (CIS) report regarding allegations of improper care related to RPN #104's medication administration practices. Three registered staff reported allegations of staff to resident incompetent and improper care related to medication administration. The allegation by the registered staff indicated that RPN #104 had administered several residents' medication prior to their scheduled times. The Administrator and Director of Care (DOC) indicated that the video evidence of the RPN's medication pass was viewed, and it was determined that several residents medications were not administered at their scheduled times, as specified in the medication pass policy. They further indicated that some residents received double dosing of medication or medication was given hours prior to their scheduled administration times. Two registered staff indicated to Inspector #601 that the RPN had left work early a few months prior to the medication incident reported in the CIS. The registered staff indicated that when the RPN had left work early, they had discovered that the RPN had documented that several residents had received their medication prior to their scheduled times. The registered staff indicated that they had verbally reported the allegations of improper medication administration to management, on the following day. Record review of the date first reported by the registered staff for several residents identified that the RPN had documented on the residents Medication Administration Record (MAR) that medication had been administered greater than one hour prior to their scheduled administration times. The allegations of the RPN's improper medication practice was not investigated a few months prior, and medication incident reports were not completed for the two medication incidents involving the RPN's medication practices. The residents were at risk when the RPN was not administering the residents medication at their scheduled times and when immediate action wasn't taken to assess the residents to determine if there was an adverse drug reaction when the medication incidents were discovered by the registered staff.

Sources: Review of CIS, the Medication Pass policy, resident #002, #003, #004, #005, #007, #008, #009, #012, #013, #015's, and #016's e-MAR, progress notes, the internal investigations, and interviews with RPN #105, RPN #106, RN #116, RPN#103/Manager of resident quality IPAC lead, DOC, and the Administrator. [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 to ensure 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, (b) is complied with, to be implemented voluntarily.

WN #3: 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately notified when there was suspicion an RPN was improperly administering medication that posed a risk of harm to several residents.

The Ministry of Long-Term Care received a Critical Incident System (CIS) report days after the incident occurred regarding allegations of incompetent and improper care related to RPN #104's medication administration practices. The allegation by three registered staff indicated that the RPN administered several residents' medication prior to their scheduled times. It was identified during the inspection that two registered staff had reported allegations to management that the RPN had administered several residents' medications prior to their scheduled administration times, a few months prior. The Ministry of Long-Term Care information line was not notified of the first allegations. The Administrator acknowledged a Critical Incident System (CIS) report was not completed and the Director was not notified of the allegations a few months prior to the CIS that was submitted. The two allegation of improper medication administration should have been immediately reported to the Director to allow for proper follow up into the allegations of the RPN improperly administering medication by not following the directions of the physician.

Sources: Review of CIS, interviews with RPN #105, RPN #106, the Administrator, and Director of Care. [s. 24. (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 to ensure when 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #023 was transferred safely when staff used the improper size sling while transferring the resident.

The Ministry of Long-Term Care received a Critical Incident System (CIS) report regarding allegations of incompetent or improper treatment of a resident when the sling straps supporting the resident's thighs failed while the resident was being transferred with a mechanical lift and the resident sustained a minor injury. The resident's plan of care at the time directed to transfer the resident with a specified size sling. The internal investigation determined the PSWs used the improper sling while transferring the resident and the straps tore. The Director of Care (DOC) indicated the PSWs transferred the resident using the improper size sling and the resident's plan of care was not followed. The PSWs did not safely transfer the resident when they used the improper size sling for the resident.

Sources: Record review of CIS, progress notes, care plan, PSWs work sheets, and observation of directions for sling use at bedside, and interviews with PSWs, RPNs, Physiotherapist, and DOC. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the medication incidents involving several residents was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident's Substitute Decision maker (SDM), if any, the Medical Director, the resident's attending physician or the Nurse Practitioner, and the pharmacy service provider.

The Ministry of Long-Term Care received a Critical Incident System (CIS) report that several residents had not received their medication according to their scheduled times. Staff interviews identified that there were two allegations that RPN #104 had administered several residents' medication prior to their scheduled times. The Administrator and Director of Care (DOC) indicated that the video evidence of the RPN's medication pass was viewed, and it was determined that several residents medications were not administered at their prescribed times, as specified in the medication pass policy. They further indicated that some residents received double dosing of medication or medication was given hours prior to their scheduled administration times. Two registered staff indicated to Inspector #601 that the RPN had left work early a few months prior to the medication incident reported in the CIS. The registered staff indicated that when the RPN had left work early, they had discovered that the RPN had documented that several residents had received their medication prior to their scheduled times. The registered staff indicated that they had verbally reported the allegations of improper medication administration to management, on the following day. The Administrator and DOC acknowledged that a medication incident report for each resident involved was not completed, the residents' SDMs, the Medical Director, the resident's attending physician or the Nurse Practitioner, and the pharmacy service provider were not made aware of the two medication incidents.The residents were at risk when the RPN's medication practices were not investigated after the first allegation and immediate action wasn't taken for both medication incidents to assess the residents involved to determine if there was an adverse drug reaction.

Sources: Review of CIS, the Medication Pass policy, resident #002, #003, #004, #005, #007, #008, #009, #012, #013, #015's, and #016's e-MAR, progress notes, the internal investigations, and interviews with RPN #105, RPN #106, RN #116, RPN#103/Manager of resident quality IPAC lead, DOC, and the Administrator. [s. 135. (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 to ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff recorded resident #026's symptoms of infection on every shift.

The resident's progress notes, and staff interviews identified the resident was at high risk for infection, was symptomatic for an infection on two occasions and the resident's physician prescribed two courses of antibiotics as a treatment for the resident. Review of the resident's progress notes, and staff interviews identified staff did not record if the resident was symptomatic of infection on every shift while the resident was being treated for the confirmed infections. The resident's progress notes did not include every shift documentation while the resident was being treated with an antibiotic to indicate that the resident's infections were assessed or if the treatments were effective. Registered staff acknowledged they did not assess symptoms of infection on every shift, and they should record symptoms of infection in the resident's progress notes. The resident was at risk

for discomfort when the resident's infections were not assessed, and symptoms were not recorded on every shift to determine if the antibiotic was effective in treating the resident's infection.

Sources: Resident's care plan, progress notes, Medication Administration Record, Monthly Infection tracking Sheet, and interviews with the RPN/Manager of resident quality IPAC lead and RPN #113. [s. 229. (5) (b)]

2. The licensee has failed to ensure that staff recorded resident #027's symptoms of infection on every shift and that immediate action was taken when required.

The resident's progress notes, and staff interviews identified the resident was at high risk for infection, was symptomatic for an infection on one occasions and the resident's physician prescribed antibiotics as a treatment for the resident. Review of the resident's progress notes, and staff interviews identified staff did not record if the resident was symptomatic of infection on every shift while the resident was being treated for the suspected infection. The resident's progress notes did not include every shift documentation while the resident was being treated with an antibiotic to indicate that the resident's infection was assessed or if the treatment was effective. Registered staff acknowledged they did not assess symptoms of infection on every shift, and they should record symptoms of infection in the resident's progress notes. The resident was at risk for discomfort when the resident's infections were not assessed, and symptoms were not recorded on every shift to determine if the antibiotic was effective in treating the resident's infection.

Sources: Resident's care plan, progress notes, Medication Administration Record, Monthly Infection tracking Sheets, and interviews with the RPN/Manager of resident quality IPAC lead and RPN #113. [s. 229. (5) (b)]

3. The licensee has failed to ensure that staff recorded resident #022's symptoms of infection on every shift and that immediate action was taken when required.

The resident's progress notes, and staff interviews identified the resident was at high risk for infection, was symptomatic for an infection on five occasions and the resident's physician prescribed five courses of antibiotics as a treatment for the resident. Review of the resident's progress notes, and staff interviews identified staff did not record if the resident was symptomatic of infection on every shift while the resident was being treated for the confirmed infections. The resident's progress notes did not include every shift

documentation while the resident was being treated with an antibiotic to indicate that the resident's infections were assessed or if the treatments were effective. Registered staff acknowledged they did not assess symptoms of infection on every shift, and they should record symptoms of infection in the resident's progress notes. The resident was at risk for discomfort when the resident's infections were not assessed, and symptoms were not recorded on every shift to determine if the antibiotic was effective in treating the resident's infection.

Sources: Resident's care plan, progress notes, Medication Administration Record, lab results from April to November 2021, Monthly Infection tracking Sheets, and interviews with the RPN/Manager of resident quality IPAC lead and RPN #113. [s. 229. (5) (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 The licensee shall ensure that on every shift the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the report to the Director included the names of the residents involved and staff who discovered the residents had not received their medication at their scheduled times.

The Ministry of Long-Term Care received a Critical Incident System (CIS) report regarding allegations of incompetent or improper care of several residents related to RPN #104's medication administration practices. The CIS did not include the names of the residents involved or the staff who had discovered that residents received medication prior to their scheduled times. The Administrator and Director of Care acknowledged that the residents and staff names involved in the internal investigation had not included in the report to the Director. Including the resident and staff involved in the CIS report allows for proper follow up with the people involved in the incident.

Sources: Review of CIS, interviews with RPN #105, RPN #106, the Administrator, and Director of Care. [s. 104. (1) 2.]

Issued on this 7th day of January, 2022

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

Original report signed by the inspector.