Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2017	2017_563670_0001	001755-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE MUNICIPALITY OF CHATHAM-KENT
519 King Street West CHATHAM ON N7M 1G8

Long-Term Care Home/Foyer de soins de longue durée

RIVERVIEW GARDENS
519 KING STREET WEST CHATHAM ON N7M 1G8

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

DEBRA CHURCHER (670), ANDREA DIMENNA (669), DOROTHY GINTHER (568), JENNA BAYSAROWICH (667), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 6, 7, 8, 9, 10, 13, 14, 15, 16 and 17, 2017.

Inspector Tracy Richardson (#680) was also present for this inspection.

During the course of the inspection, the inspector(s) spoke with 40+ Residents, the representative of the Family Council, representative of the Resident's Council, Administrator, Director of Care, Maintenance Supervisor, twenty six Personal Support Workers, fourteen Registered Practical Nurses, two Nurse Managers, six Registered Nurses, four Dietary Aides, four Environmental Service Workers, two Food Service Supervisors, Pharmacist and Registered Dietician.

During the course of the inspection, the inspectors toured all resident home areas, observed dining services, medication rooms, medication administration and medication count, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. A resident was observed on two occasions during the inspection to have received tray service in their room.

The resident was interviewed during the inspection and stated that they normally received a tray at meals. The resident reported that they preferred to stay in their room for now.

A review of the resident's progress notes stated that the resident had not attended meals in the dining room and had received tray service regularly for an extended period of time. The progress notes documented that tray service was provided as per the resident's request.

Interview with a PSW who stated that if a resident requests a tray in their room the staff would provide it however they would be encouraged to attend the dining room for meals.

Interview with an RN who shared that there was no documentation for residents receiving tray service, but that staff communicate with each other at the daily report to relay information about residents requesting or requiring tray service. The RN stated that the resident had regularly been refusing to get out of bed.

Interview with an RPN who shared that the resident had been receiving tray service for an extended period of time.

The home's policy "Food Service Management" related to tray service last revised August 2016, stated "Residents are encouraged to attend the dining rooms for all their meals. Exceptions will be made for ill residents or residents whose care plan indicated otherwise."

The resident's care plan was reviewed and did not include any information regarding the resident's preference for tray service.

The licensee failed to ensure that the resident's plan of care was based on an assessment of the resident and the needs and preferences of the resident. [s. 6. (2)]

2. During an interview with a resident, they shared that they were very aware of the healthcare system from past experiences and appreciated if staff provided explanations of the care provided prior to providing it. The resident expressed that they preferred to be notified and aware of the staff names prior to care being initiated. The resident further expressed their feeling related to the home's safety protocols. The resident also expressed dissatisfaction with staff communicating information about their diagnosis and

care needs openly in public areas.

Clinical record review of the resident's care plan under the Getting to Know Me section listed multiple things that the resident identified as not liking.

A Registered Nurse (RN) identified that the resident had specific likes, dislikes and expectation related to the care provided.

A PSW stated that as long as staff knock and speak quietly when approaching the resident for care there were no issues. The PSW stated that the resident gets upset when staff approach them with a loud voice and that sets the mood for care.

While two inspectors were present interviewing the resident with the door closed, a staff member was observed entering the resident's room without knocking. The Inspector asked the staff to come back once inspectors were finished meeting with the resident. The staff member stated they were just wondering if the resident wanted a beverage or snack. The resident stated that they may want something later once finished meeting with inspectors.

When asked if the resident's preferences regarding staff interaction with them would have been expected to be found in the resident's plan of care, an RN stated that this would be an expectation. The RN shared that this information was not included in resident's plan of care, an RPN further acknowledged that this information should be included in resident's plan of care.

When another RPN was asked what was included in resident's plan of care related to dignity, choice, or privacy, the RPN indicated that there was no specific information included regarding this specifically for the resident, as treating residents with dignity and respect applied to everyone.

The DOC shared during an interview that they were unaware of the resident's concern with safety and could understood how it would have been difficult for them to not be informed about the home's planned event. The DOC further acknowledged that the resident appreciated being informed and made aware about everything regarding their care.

The licensee failed to ensure that the plan of care for the resident was based on an assessment of the resident and the resident's needs and preferences.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on September 28, 2016 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2016_257518_0045. [s. 6. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, 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. During a dining observation a resident was observed to be absent during meal service. A Personal Support Worker (PSW) was interviewed and asked about the plan for this resident. The PSW stated that there was a plate saved for the resident and that the resident would receive tray service.

The Inspector observed portioned mushroom soup bowls sitting on a tray on top of the service counter at during a lunch service. A Dietary Aide stated during an interview that

the soups were extras and were to be disposed of. The Dietary Aide proceeded to take them off the counter for disposal.

The Inspector observed the resident in their room on three occasions during the lunch service, with no meal noted. The Inspector observed a Registered Practical Nurse (RPN) approach the resident in their room and offered them a nutritional supplement. The RPN spoke to the Inspector and stated that the resident was interested in having something to eat. The RPN then re-entered the resident's room and asked resident if they wanted to come to the dining room. The RPN then exited the resident's room and told the Inspector that there may have not been any lunch available anymore but that there might be a peanut butter sandwich to offer them. The RPN went back into the resident's room and then told the Inspector that the resident was sleeping now and did not want to come to the dining room.

The home's policy titled Food Service Management: Early or Late Meals, Packed Meals and Tray Service, last revised August 2016, stated that residents may receive an early or late breakfast, lunch, or dinner upon request by nursing and that meals consistent with the menu will be provided. This policy also stated that nursing will notify the Dietary staff if tray service is required for any resident and trays are provided after all residents in the dining room have been served and nursing are available to deliver and monitor.

Director of Care (DOC) shared during an interview that the home's expectation when a resident did not come to the dining room for a meal would be that they would have received a tray. DOC acknowledged that the home's expectation was that the resident would have received a tray.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during this inspection. There was a compliance history of this legislation being issued in the home on October 5, 2015 as a Written Notice (WN) in a Resident Quality Inspection #2015_206115_0028 . [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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Review of the clinical record stated that a resident had an alteration in skin integrity. Intervention of weekly skin and wound assessments were added to the treatment record. Initial skin and wound assessment was documented in Point Click Care (PCC). There were no documented skin and wound assessments noted on two occasions.

The home policy "Medical Care Related to Wound Care", last revised Nov 25, 2016 stated that "Registered staff will: (2.) With a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds: a. conduct a skin assessment, weekly and sign on Treatment Administration Record (TAR) and document findings in Point Click Care (PCC) in skin and wound assessment".

Director of Care (DOC) acknowledged that the policy states, and it would be an expectation of the home, that a skin and wound care assessment would be documented weekly in PCC and accompany a signature on the TAR for a resident with altered skin integrity.

The licensee has failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during this inspection. The compliance history of the home is a two with one or more unrelated non-compliance in the last three years. [s. 50. (2) (b) (iv)]

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 any residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. During the Resident Quality Inspection, the Inspector observed a resident in their room during meals for three meals during the inspection. A tray was brought to the resident's room on two occasions and staff did not remain in the room to assist the resident with eating. On one occasion a Personal Support Worker (PSW) entered the room, encouraged the resident to eat their meal, and left the room. During the course of that meal, the Inspector observed that only one staff member entered the room for monitoring of this resident. On one occasion the Inspector observed the resident with tray service. It was noted that the food was in the room for thirty five minutes and no staff member entered the room to monitor the resident. The food had been opened but nothing had been touched on the tray. Ice cream was also served to the resident on this tray. Observed on another occasion the resident was served a tray and a PSW sat with the resident to encourage them to eat. The resident was eating and conversing with the staff member. The PSW stated at the completion of the meal that the resident had eaten eighty per cent of the entree and a few bites of the side. They said that this was good for the resident.

Review of the plan of care for the resident stated that the resident required assistance related to a cognitive deficit and that they should be provided with set up assistance and encouragement for eating.

During a review of the "Food Service Management" policy, revised August 2016, it indicated that all residents should be provided supervision during meals and snacks.

In an interview with a PSW they stated that the resident often received tray service and would eat in their room. PSW's usually sit with the resident while they eat to keep an eye on them and to encourage them to eat. The resident was capable of feeding themself but needed encouragement. During an interview with a Registered Practical Nurse (RPN) they shared that the resident did not eat well and required a supplement. The RPN stated that if the resident did not eat at least fifty per cent of their meal they were given an extra supplement. The RPN further indicated that the resident was not a high

risk for choking and was capable of feeding themself.

A Registered Nurse (RN) stated that they do not routinely give residents trays in their room. If the resident stays in their room and are high risk for choking staff must stay with them. Otherwise staff should monitor the resident every fifteen minutes.

During an interview the Director of Care (DOC) DOC shared that the home's expectation for monitoring resident's eating in their rooms would be the same for residents eating in the dining room. Monitoring level would be dependent on the resident's cognitive level and swallowing difficulties. If a resident was compromised at all, the expectation would be that the resident would receive constant supervision while eating. The DOC acknowledged, based on observations provided by the Inspector of the resident when eating in their room, that if the resident needed more assistance and prompting due to impaired cognition, staff should have remained with them to ensure that they had eaten.

The licensee failed to ensure the monitoring of all residents during meals.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during this inspection. The compliance history of the home is a two with one or more unrelated non-compliance in the last three years. [s. 73. (1) 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 to ensure that the home has a dining and snack service that includes the monitoring of all residents during meals, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. During observation of the medication count, an open ampoule was observed in a plastic cup in the narcotic drawer of the medication cart.

Medical Pharmacy policy "Medications for Injection-Safe Use of Medications Supplied in Ampoules 10-8" revised January 2014, stated; "Once the desired quantity is drawn into the syringe, the remaining quantity should be discarded using procedures appropriate to the medication. (e.g. wasting of a monitored medication requires a witness and appropriate documentation.) Do not save residual medication for subsequent injections unless explicitly directed by administrative staff and/or the manufacturer. The storage of opened ampoules with residual is not acceptable."

The Inspector interviewed two RPN's. One RPN stated that they had taken two separate doses out of the ampoule of dilaudid for a resident during their shift and were wasting the remainder with the oncoming RPN. Both RPN's stated this was a standard practice to keep an open ampoule during their shift and waste the remainder at the end of their shift.

A Registered Nurse (RN) was interviewed and acknowledged that it was common practice in the home to open an ampoule and keep it in the narcotic drawer during a shift for further use if not all of the medication was used. The RN stated that pharmacy had told them to do this.

During interview the Director of Care (DOC) acknowledged that staff had been instructed to open an ampoule and keep it in the narcotic drawer for further use during the shift with the expectation that the nurse that originally opened the ampoule was the only nurse that utilized any drug from the ampoule.

The DOC later returned with the home's policy "Medical Care", policy code NUR MED revised November 25, 2016. The DOC shared that the home's policy would supersede the pharmacy policy. The policy stated; "To pre-fill syringes prior to administering to a

resident when they will be receiving multiple doses on your shift. The RN/RPN will pre-fill the syringes from the ampoule (maximum 4 syringes) at the beginning of your shift. The RN/RPN will label each syringe with the resident and drug name, date and time. The pre-filled syringes will be kept in the narcotic bin. Two Registered staff will discard the medication remaining in the ampoule in a bio hazardous container and sign off the discard on the narcotic count sheet. Only the RN/RPN that filled the syringes will administer the medication to the resident. At the end of the shift if any pre-filled syringes remain unused they will be discarded as above and signed off by two Registered staff."

During interview the Pharmacist stated that they did not feel that keeping an open ampoule in a narcotic drawer was safe or best practise. The Pharmacist's expectation was that once a dose was removed by the registered staff the expectation would be that the remaining medication would be immediately wasted.

The Inspector reviewed the home's policy as well as the pharmacy policy with the Pharmacist. The Pharmacist stated that it would be appropriate to pre-fill syringes from the ampoule only if labelled correctly and stored in the double locked cart. The Pharmacist also stated that it must be the same registered staff that drew the medication up, labelled the syringes, administered the drug and any remaining drug was wasted at the end of their shift. The Pharmacist stated that they had not previously reviewed the home's policy.

The licensee has failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate dispensing, storage, administration and disposal of all drugs used in the home.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issues was isolated during this inspection. The compliance history of the home is a two with one or more unrelated non-compliance in the last three years. [s. 114. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, administration, and destruction and disposal of all drugs used in the home, 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. Observations of the tub/shower rooms were made during the Resident Quality Inspection. The Inspector observed that there was one opened roll-on deodorant not labelled for a specific resident in two separate tub rooms. On a separate occasion the Inspector noted that in a tub room there was one roll-on deodorant with no name, an opened and partially used bar of soap, and an unlabelled denture cup with two soap bars inside sitting beside the tub. During a separate observation of a tub room, two bars of soap were noted open and not labelled, as well as two unlabelled roll-on deodorants beside the portable shower chair. The Inspector subsequently observed an additional two tub rooms and observed four roll-on deodorants by the tub which were not labelled for a specific resident and a bar of soap laying by the shower chair.

A review of the home's policy Admission Process, revised July 2014, stated that all personal clothing, hygiene articles, and personal equipment should be labelled.

During an interview with two Personal Support Workers (PSW's) they stated that some residents have their own individual soap bars, but they would be labelled and put in their personal storage containers in the tub room. They also said that soap bars should not be left out by the tub. Both PSW's acknowledged that all personal care items for residents were to be labelled.

During an interview with the Director of Care (DOC) and an Registered Nurse (RN) Infection Prevention and Control (IPAC) Lead, they acknowledged that resident's soap bars and roll on deodorants should be labelled and put in their individual basket and not shared between residents. They stated that it was the home's expectation that personal care items such as soap bars and deodorants should be put in containers that were labelled for the specific resident. They acknowledged that two soaps in one unlabelled container was not acceptable and that soap bars should be placed in individual labelled containers for use. The DOC and the RN acknowledged that all deodorants' being used for residents should be labelled and be put in their individual baskets in the tub room.

The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during this inspection. The compliance history of the home is a two with one or more unrelated non-compliance in the last three years. [s. 229. (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 to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that where bed rails are used, the resident was assessed and their bed system evaluated in accordance with evidence based practices to minimize risk to the resident.

During observation throughout stage one of this inspection, the Inspector noted gaps between the mattress and the footboard and potential entrapment risks on a resident's bed.

The resident's care plan stated resident used header rails (2) to move in bed, logo in room stated the use of quarter rails at the head of the bed.

The home's policy Bed Safety-Prevention of Entrapment issued April 2006 revised November 25, 2016, section eight of procedure stated "in relation to entrapment, bed rail use shall also be assessed regularly using the Bed Rail Safety Analysis". Section nine of

procedures stated "Bed Rail Safety Analysis may be conducted by any Riverview Gardens Staff, but preferably the Registered Nurse. Bed rail use shall be assessed on admission, whenever Entrapment Bed Audits are performed and a bed does not pass all entrapment zones, whenever a resident changes his/her mattress, bed frame or any other bed-related products and whenever a Riverview Gardens Staff feels it is necessary for resident safety".

The Inspectors and home staff were unable to locate a Bed Rail Safety Analysis or a Bed Safety Analysis for the resident. There was a Bed System Measurement Device Test Results Worksheet completed that stated a failure of zone seven.

The Maintenance Supervisor stated that the home’s process was that bed assessments were tracked via work orders but there was no specific tracking for the mattress types and numbers to correlate with the bed frames.

The Director of Care (DOC) stated that the Bed System Measurement Device Test Results Worksheet is completed by maintenance every other year, and involves maintenance testing beds and mattresses, additionally the Registered Nurses (RN’s) test beds on admission and readmission using both the Bed Rail Safety Analysis and the Bed Safety Analysis. The DOC stated that she was not aware of any tracking of bed systems in the home and acknowledged that the resident and their bed system should have been assessed and evaluated and that there was no documentation that the resident and their bed system were assessed or evaluated. [s. 15. (1) (a)]

2. The Licensee has failed to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During observation throughout stage one of this inspection, the Inspector noted gaps between the footboard and mattress and potential entrapment risks on beds being utilized by two resident's.

The home’s policy titled “Bed Safety-Prevention of Entrapment” issued April 2006 revised November 25, 2016 section seven of procedure stated, “appropriate entrapment mitigation products and interventions shall be utilized whenever possible-the intention of which are to fill gaps and spaces where the resident’s head, neck or chest may become lodged/trapped. Specialized gap fillers purchased for this purpose may only be used. Any Riverview Gardens Staff may utilize gap fillers at any time, but shall endeavor to discuss the use of such devices with the Registered Nurse before doing so, whenever possible.”

Reviewed the Bed Measurement Device Test Results Worksheet located in the Bed Measurement Results binder in the maintenance office and the bed of a resident had a Bed System Measurement Device Test Results Worksheet that stated a fail of zone seven.

Reviewed the Bed Assessment Binder at the nurses station and the bed of a resident had a Bed Rail Safety Analysis and a Bed Safety Analysis that stated that the lower bed rails can be removed and replace mattress with eighty two inch mattress when one becomes available. The bed belonging to the resident also had a Bed System Measurement Device Test Results Worksheet that stated a pass for all zones with the exception of zone seven.

The Maintenance Supervisor told Inspectors that at this time the home is slowly purchasing new beds for the home that have eighty two inch mattresses and shared that they are aware that at this point most beds in the home are failing zone seven as the mattresses are not long enough. The Maintenance Supervisor stated the home does not have any knowledge of the use of specific items to fill gaps in failed entrapment areas and that they use the mattress keeper to keep the mattress from sliding down the frame.

An RN stated that the home was aware that zone seven was known to be an increased risk for entrapment and that the home was in the process of obtaining eighty four inch mattresses because their current mattresses do not reach the foot board.

Interview with the DOC and the Maintenance Supervisor who shared that the home's intervention to minimize entrapment risk related to zone seven was to replace current mattresses over the last two years and that the home currently has fifteen to twenty of these new mattresses in the home. The Maintenance Supervisor stated that the current beds were not engineered to have corner mattress keepers, and only the new beds have corner mattress keepers. The Maintenance Supervisor acknowledged that no interventions have been implemented to reduce the risk of zone seven entrapment.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The compliance history of the home is a level two with one or more unrelated non-compliance in the last three years. [s. 15. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. A review of a resident's progress notes included a Behaviour Note, that stated staff should be aware of a specific trigger for this resident's responsive behaviors. The resident's care plan was reviewed and included a specific focus with multiple specific interventions.

The resident was observed on multiple occasions, including one occasion when resident was observed to be in their room with the door closed.

A Personal Support Worker (PSW) was interviewed and stated that the resident's triggers and interventions to prevent responsive behaviours were listed on Point Of Care (POC), in progress notes, and on a whiteboard behind the nursing station by Behavioural Support Ontario (BSO) team. The PSW was able to indicate a specific triggers and interventions that they use for this resident.

Another PSW was interviewed and stated that staff can obtain information regarding residents’ responsive behaviours in Point Click Care (PCC) or can ask full-time coworkers who are familiar with residents. The PSW was able to state some triggers and interventions that they use for the resident's responsive behaviors.

An interview was conducted with a Nurse Manager and a PSW. The PSW stated that the resident was being followed by the BSO team and that PSW's report responsive behaviours to registered staff, and that information related to responsive behaviours can be found in the resident’s kardex. The Nurse Manager shared that the home tries to be specific about interventions for responsive behaviours. The Nurse Manager was unable to list any interventions in place addressing a specific trigger for responsive behaviours. The Nurse Manager stated that an intervention that the staff were currently using was not an intervention for the resident. The PSW reviewed resident’s plan of care and acknowledged that a current intervention being utilized was not part of the plan of care.

The licensee failed to ensure that written strategies, including techniques and interventions, were developed to prevent, minimize or respond to the behaviours.

The severity was determined to be a level one as there was minimal risk. The scope of this issue was isolated during this inspection. The compliance history of the home is a two with one or more unrelated non-compliance in the last three years. [s. 53. (1) 2.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The toilet bowl in a resident's room was observed to have large, brown, rusty stains. On the same day, similar stains were observed in the bowls of prelude shower chairs in seven tub rooms.

Observation on a second occasion showed the stains were observed a second time in the toilet bowl of the resident's room and in the bowls of prelude shower chairs in seven tub rooms.

A housekeeper stated that housekeeping staff clean the tub rooms daily, but that all tubs/showers were cleaned by nursing staff. The housekeeper stated that any identified stains should be cleaned by the staff who saw the stain, then the staff should notify housekeeping so the area can be disinfected.

A Personal Support Worker (PSW) stated that the tubs/showers in the tub rooms were cleaned by PSWs between every resident. The PSW reported that if a stain was identified by a PSW, a work order for maintenance would be initiated by the PSW.

Interview with an additional housekeeper who stated residents' bathrooms were cleaned daily and a thorough cleaning is completed weekly. The housekeeper stated that if a stain was noticed, it would be cleaned at that time; if the stain could not be removed, they would report the stain to their supervisor or submit a maintenance work order.

The Maintenance Supervisor stated that there was no process in place for maintenance staff to make rounds in common areas and residents rooms, but maintenance staff check areas as they are working throughout the home. The Maintenance Supervisor shared

that the maintenance department must rely on staff and residents to identify issues and submit work orders. The Maintenance Supervisor shared that all staff and residents had the ability to initiate a work order. The Maintenance Supervisor stated that if stains could not be removed, the equipment would be replaced. The Maintenance Supervisor shared that no work orders have been submitted related to stained prelude shower chairs.

The Maintenance Supervisor acknowledged the stains in the bowl of the prelude shower chair, and stated the stains were likely due to mineral deposits from water running down the bowl related to a leaky valve. The Maintenance Supervisor stated that all stained bowls in prelude shower chairs would be cleaned and valves would be replaced to prevent future staining. The Maintenance Supervisor stated that staff were expected to submit work orders for stained equipment, such as those identified in the bowls of the observed prelude shower chair.

The licensee failed to ensure that procedures were implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

The severity was determined to be a level one as there was minimal risk. The scope of this issue was isolated during this inspection. The compliance history of the home is a two with one or more unrelated non-compliance in the last three years. [s. 90. (2) (d)]

Issued on this 19th day of May, 2017

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

Original report signed by the inspector.