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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Feb 14, 2016	2016_246196_0001	034906-15	Resident Quality Inspection

Licensee/Titulaire de permis

RIVERSIDE HEALTH CARE FACILITIES, INC.
110 VICTORIA AVENUE FORT FRANCES ON P9A 2B7

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

RAINYCREST
550 OSBORNE STREET FORT FRANCES ON P9A 3T2

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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577), KATHERINE BARCA (625), SHEILA CLARK (617)

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): January 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 2016

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI Coordinator, Environmental Service Manager (ESM), Registered Dietitian (RD), residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

23 WN(s)
15 VPC(s)
2 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 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 was complied with.

The policy "Medication Double Check Policy" effective July 29, 2015, stated that an independent double check is required prior to the administration of high alert medications.

Inspector #625 reviewed resident #017's January 2016 MAR and found that 28 out of a required 35 initials, indicating an independent second check occurred, were not signed for. RPN #112 stated that the independent second checks had not been completed for a high alert medication administration where the second check was not signed for on the MAR. In addition, RPN #112 indicated that the second check for the high alert medication they administered that morning had not been done and the MAR reflected this as there was no initial for the morning high alert medication check.

During an interview with Inspector #625, the DOC stated that this particular medication was a high alert medication and that policy required an independent double check of the medication and should be signed for by both staff in the MAR. The DOC reviewed the January 2016 MAR for resident #017 and counted 28 out of 35 independent double checks were not signed for. The DOC stated that not signing for check indicated the check was not completed. [s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place was complied with.

(A) The home's policy "Narcotic Counts Procedure" stated that the "Narcotic/Controlled Drug Record" should be signed once the count conducted by two registered nursing staff is completed.

During the inspection, on a particular day, at approximately 1100 hrs, a review of the narcotic and controlled drug count was completed by Inspector #625. The Inspector noted that the count conducted at 0630hrs on the "Narcotic/Controlled Drug Record" for one of the units, for scheduled and prn (as needed) medications, had been signed for by one registered staff member, not two as required by the policy. RPN #112 stated that they had not yet signed for the count that had been completed four hours earlier, but reported they should have signed at the time of the count.

During an interview with Inspector #625, the DOC reviewed the "Narcotic/Controlled Drug Record" and stated that both registered nursing staff members should have signed the count at that time of completion.

(B) The home's policy "Managing Narcotic/Controlled Drugs Procedure" stated that, when administering narcotic or controlled drug, the registered nursing staff should enter the time of administration, enter the remaining amount of the drug left, sign for administration in the signature area and, if more than one drug is administered to more than one resident on the same medication pass, one line should be used to document all drugs administered during the medication pass.

A review of the narcotic and controlled drug count was completed by Inspector #625. The number of medications present, differed from the values recorded on the "Narcotic/Controlled Drug Record" for one of the units, for both the scheduled and prn (as needed) records. Inspector noted that the last entries on both sheets were the count conducted that day at 0630hrs by registered nursing staff.

During an interview with Inspector #625, RPN #112 stated that they had administered scheduled narcotics and controlled medications during the morning medication pass to multiple residents which they had not recorded on the "Narcotic/Controlled Drug Record" for scheduled medications. RPN #112 also stated that they had administered two controlled medications which the RPN had not yet deducted from the "Narcotic/Controlled Drug Record" for prn medications. RPN #112 stated that they were required to sign for the narcotic and controlled medications at the times they had been

administered to the residents but had not done so.

During an interview with Inspector #625, the DOC reviewed the count sheets and stated that registered nursing staff are required to sign for each narcotic or controlled medication administered on the sheets as soon after each individual administration as possible. [s. 8. (1) (b)]

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

Inspector #625 reviewed the medical directives #RCS F-80-3 which listed types of medication and for what purpose, dosages, route of administration and the duration of the medication administration.

The home's policy "New Physician Orders" stated that all medication orders should specify quantities and/or duration of therapy for all medications ordered, medication orders should be transcribed onto the MAR sheet, and lines should be drawn through boxes on the MAR to the date and time the first dose was given.

(A) A review of resident #011's December 2015 MAR identified a handwritten entry for one of the medications listed on the medical directives, which was initialed as administered on a specific date that month.

During an interview with Inspector #625, RPN #110 stated that orders processed by staff should contain the date and time the entry was placed on the MAR, the signature of the staff member who entered it on the MAR, and the correct dose ordered.

During an interview with Inspector #625, the DOC stated that orders processed by staff should contain the signature and date the medication was placed on the MAR, the duration of the order, lines drawn through the dates prior to and after the order duration, and the dose that was administered.

The entry on resident #011's December 2015 MAR did not contain the signature of the staff member processing the order onto the MAR, did not contain the date the medication was placed on the MAR, did not accurately transcribe the order including the duration, frequency, route, dose range, and did not have lines drawn to indicate the start and end dates of the medication.

(B) A review of resident #016's December 2015 MAR identified affixed labels for two different medications as listed in the medical directives.

During an interview with Inspector #625, RPN #110 stated that processing of the orders onto the MAR required the signature, date and time processed by staff, which the RPN stated were missing.

During an interview with Inspector #625, the DOC stated that the processing of the orders onto the MAR should contain the signature and date the medication was placed on the MAR, lines drawn through the dates prior to the initial dose being administered and after the 72 and 48 hour durations of the orders ended, which the DOC stated were missing.

The entry on resident #016's December 2015 MAR did not contain the signature of the staff member processing the order onto the MAR, did not contain the date or time the medication was placed on the MAR, and did not have lines drawn to indicated the start and end dates of the medications.

(C) A review of resident #015's September 2015 MAR identified an affixed label for one of the medications as listed on the medical directives.

During an interview with Inspector #625, RPN #110 stated that processing of the orders onto the MAR required the signature, date and time processed by staff, which the RPN stated were missing.

During an interview with Inspector #625, the DOC stated that the processing of the orders onto the MAR should contain the signature and date the medication was placed on the MAR, lines drawn through the dates prior to the initial dose being administered and after the 48 hour durations of the orders ended.

The entry on resident #015's September 2015 MAR did not contain the signature of the staff member processing the order onto the MAR, did not contain the date or time the medication was placed on the MAR, and did not have lines drawn to indicated the start and end dates of the medication.

(D) A review of resident #015's September 2015 MAR identified a handwritten entry for a medicine as listed on the medical directives, signed as administered on a specific day that month.

During an interview with Inspector #625, RPN #110 stated that processing of the orders onto the MAR required the signature, date and time processed by staff, the dose, time administered and identification that it was a medical directive, which the RPN stated were missing.

During an interview with Inspector #625, the DOC stated that the processing of the orders onto the MAR should contain the signature and date the medication was placed on the MAR, lines drawn through the dates prior to the initial dose being administered and after the 72 hour duration of the orders ended, the dose range ordered, the frequency and route of administration, and that the order was a medical directive, all of which the DOC identified were missing. The DOC also identified that the dose and time of medication administration were not recorded on the MAR when it was administered.

The entry on resident #015's September 2015 MAR did not contain the signature of the staff member processing the order onto the MAR, did not contain the date or time the medication was placed on the MAR, did not have lines drawn to indicate the start and end dates of the medication, did not list the frequency and route of administration or that the order was a medical directive. In addition, staff did not record on the MAR the dose and time of the medication administered on a specific day in September 2015.

(E) A review of resident #015's October 2015 MAR identified a handwritten entry for the administration of two doses of medicine, as per the medical directive, on two consecutive days in that month.

During an interview with Inspector #625, RPN #110 stated that processing of the orders onto the MAR required the signature, date and time processed by staff, which the RPN stated were missing.

During an interview with Inspector #625, the DOC stated that the processing of the orders onto the MAR should contain the signature and date the medication was placed on the MAR, lines drawn through the dates prior to the initial dose being administered and after the 72 hour duration of the orders ended, the dose administered on the two days, all of which the DOC identified were missing.

The entry on resident #015's October 2015 MAR did not contain the signature of the staff member processing the order onto the MAR, did not contain the date or time the medication was placed on the MAR, did not have lines drawn to indicated the start and

end dates of the medication and did not identify the dose administered on the two specific days. [s. 8. (1) (b)]

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 O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee had failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: 1. A change of 5 per cent of body weight, or more, over one month.

Inspector #577 reviewed the health care records for resident #005. The weight record identified that over an approximate one month period, the resident had a weight change of five per cent or more of body weight. A review of the dietary assessments completed by the Registered Dietitian (RD) revealed that an admission assessment was completed the day prior to the documentation of the resident's weight, and a quarterly assessment was dated just over one month later.

The Inspector conducted an interview with the RD who reported that the Goldcare computer program, generates an email notification when there is a weight loss and they could not confirm whether they received a notification through Goldcare. They confirmed that the weight change was considered a five per cent weight change and they did not

assess for the resident's weight change in May 2015.

Inspector #577 conducted an interview with RN #106 and they reported that they could not confirm whether they had sent a referral to the RD in the month of resident #005's weight change.

Inspector #577 conducted an interview with the DOC and they confirmed that it was the home's expectation that the RD assess residents on admission, quarterly and with significant changes, and that the Goldcare computer program would generate an email notification regarding a resident's weight loss. The DOC further confirmed that it was expected that registered staff also email the RD for concerns and the RD would assess residents for weight change and specifically a five per cent weight change for resident #005. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The licensee had failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: 1. A change of 5 per cent of body weight, or more, over one month.

Inspector reviewed the health care records for resident #003. The weight record identified that over an approximate one month period, the resident had a weight change of five per cent or more of their body weight. A review of dietary assessments completed by the RD revealed an admission assessment completed in early summer 2015, and a quarterly assessment done approximately two and a half months later and again three months later.

Inspector #577 conducted an interview with the RD and they reported that the Goldcare computer program, generates an email notification when there is a weight loss and they could not confirm whether they received a notification through Goldcare. They confirmed that resident #003 had a weight change greater than five per cent in one month and they did not assess the resident's weight change.

Inspector #577 conducted an interview with the DOC and they confirmed that it was the home's expectation that the RD assess residents on admission, quarterly and with significant changes, and that the Goldcare computer program generates an email notification regarding resident's weight loss. They further confirmed that it was expected that registered staff also email the RD for concerns and the RD would assess residents for weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Inspector #196 observed RPN #134 administer an injection to resident #041 on one of the units. After giving the injection, RPN #134 made an infantilizing statement towards resident #041.

At 1640hrs, Inspector observed RPN #134 take resident #042 into the medication room on the same unit and then administered an injection.

Inspector conducted an interview with RPN #134 and they reported that they had administered resident #041's medication in the common area, as the resident's arm was directed at the wall. They also reported that they had taken resident #042 into the medication room to provide them with privacy.

Inspector conducted an interview with the DOC and they reported that the home's expectation is that treatment, including injections, are to be given in a private area and not in a common resident area. [s. 3. (1) 1.]

2. The licensee failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be protected from abuse.

A Critical Incident System (CIS) report was submitted to the Director in 2015, for an incident of alleged staff to resident abuse.

Inspector #617 reviewed the home's investigation summary of the incident which indicated that PSW #121's actions were abusive and the PSW was disciplined.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy titled "Abuse and Neglect Zero Tolerance" which indicated that the home is committed to a zero tolerance of abuse or neglect of residents by any person.

Inspector #617 reviewed the personnel file of PSW #121 which indicated that the employee had two prior occasions of discipline for neglectful care and being disrespectful towards residents. [s. 3. (1) 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 that ensures every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and every resident has the right to be protected from abuse, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Inspector #577 observed elevated bed rails for resident #005 during the inspection, on three occasions.

The Inspector reviewed the plan of care and MDS for resident #005, which did not indicate the use of bed rails.

The Inspector conducted an interview with PSW #107 and they stated that resident #005 used bed rails.

The Inspector conducted an interview with PSW #108 and they stated that resident #005 used bed rails.

The Inspector conducted an interview with RN #109 and they confirmed that bed rails should be documented in the resident's care plan.

The Inspector conducted an interview with the DOC and they confirmed that it was the home's expectation that bed rails be documented in the care plan. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Inspector #625 reviewed resident #014's care plan which listed the use of a specific type of lift and the presence of a transfer device.

During an interview with Inspector #625, RPN #110 stated that this resident did not have a transfer device in their room. Inspector #625, RPN 110 and resident #014 attended resident's room and noted that a transfer device was not present. Resident and RPN #110 reported that resident used a specific type of lift and no longer used a transfer device.

During an interview with Inspector #625, RPN #111 stated that the transfer device was removed from resident #014's room when they started using a specific type of lift over six months prior.

During an interview with Inspector #625, the DOC stated that resident #014's care plan provided conflicting information regarding the resident's transfer devices and methods to use. [s. 6. (1) (c)]

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

During interviews with Inspector #625, resident #014 stated that they used bed rails.

During interviews with Inspector #625, resident #014, RPN #110 and RPN #111 all stated that resident #014 used two bed rails when in bed.

Inspector #625 reviewed resident #014's RAI-MDS Full Assessment, which indicated that the resident had used bed rails daily over the previous seven days and a "Seven Day Observation and Monitoring Form" was completed, which indicated that bed rails were used during this period.

Inspector #625 reviewed resident #014's current care plan, the care plan did not include the use of bed rails.

Inspector #625 reviewed resident #014's chart and identified that a "Bed Rail Assessment" form had not been completed for bed rail use and "Daily Care Record" forms completed by PSWs for a four month period in 2015 did not identify the use of bed rails.

During an interview with Inspector #625, RPN #112 stated that resident #014's chart did not contain a "Bed Rail Assessment" form and that the "Daily Care Record" forms in the resident's chart for the four month period in 2015, did not indicate that the resident used bed rails.

Therefore, the plan of care was not based on an assessment of the resident's needs and preferences with respect to bed rail use. [s. 6. (2)]

4. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

During an interview with Inspector #625, the RD stated that nursing staff obtain resident weights, record them by hand in an RD tracking spreadsheet and then nursing staff enter the weights into the resident's health care records.

Resident #011's weight in February 2015 was documented as one value and their weight was documented twice, approximately five weeks later as a much greater value. Resident #011's weight was not recorded for the month of April 2015 but was recorded in May 2015. The RD stated that they suspected that the weight of resident #011's wheelchair had not been deducted from the weights entered by nursing staff in March 2015.

Inspector #625 reviewed resident #011's weights listed in the health care record and the RD's weight tracking spreadsheet. Weights for September and October 2015, were recorded respectively, on the RD tracking spreadsheet but were not listed in the resident's health care record.

During an interview with Inspector #625, the RD stated that staff did not document the September and October 2015 weights into resident #011's health care record as required.

The November 2015 weight listed on the RD tracking spreadsheet was one value and the weight in resident's health care record was another value. The RD stated that the discrepancy could be misinterpretation of the handwritten value initially written by the PSW and interpreted differently by the nursing staff and the RD.

Therefore, the weight values obtained and used by nursing staff are not consistent with the weight values used by the RD. [s. 6. (4) (a)]

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 that ensures the plan of care sets out clear directions to staff and others who provide direct care to the resident, that the plan of care is based on an assessment of the resident and the resident's needs and preferences and that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when not being supervised by staff.

On a day during the inspection, Inspectors #577 and #625, observed a clean utility room and nursing station doors open while staff were not present. PSW #113 stated that the nursing station and clean utility room doors should be kept closed and locked and that residents were not permitted in either room.

Inspectors #577 and #625, observed a soiled utility room door was open and PSW #107 stated that the door should be kept closed and locked.

Later that same day, Inspector #625, observed on two separate occasions, that the conference room door on one unit, was open and the nursing station door was open with staff not in the area.

Inspector #625 interviewed PSW #114 and they reported that the conference room was not a resident area and RPN #111 reported that the conference room door should be kept closed and locked as there were items in the room that were potential falls hazards for residents.

The following day, Inspector #625, observed that the same conference room and nursing station doors were open and staff were not present. An interview was conducted with RPN #115 and they stated that the doors were to be kept closed and that residents should not access those areas.

Inspector #625 conducted an interview with the DOC and reported that the door to non-resident areas such as the nursing stations and conference rooms should be kept closed and locked that resident were not permitted access to those areas. [s. 9. (1) 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 that ensures that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #6: 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 were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

A review of policy "Bed Entrapment Preventions Program Registered Staff Procedures" found that, upon admission, readmission, and with any significant change in condition, each resident must be assessed for potential risk for entrapment on the bed and identified an assessment form for reference. The assessment form provided by the DOC was titled "Bed Rail Assessment".

During interviews with Inspector #625, RPN #110 and RPN #111 both stated that

resident #014 used bed rails in bed. Inspector, RPN #110 and resident #014 attended resident's room and confirmed that bed rails were in the raised position. Resident #014 stated that they used the bed rails daily when in bed and when transferring in and out of bed.

A review of resident #014's chart by Inspector #625 revealed that "Bed Rail Assessment" forms had not been completed for the resident's use of bed rails.

During an interview with Inspector #625, RPN #112 stated that they had not seen the "Bed Rail Assessment" form prior to meeting with the Inspector.

During an interview with Inspector #625, the DOC stated that the "Bed Rail Assessment" was introduced to staff in November 2015, and discussed at a registered staff meeting where staff were given direction to complete the assessments for applicable residents. The DOC stated the "Bed Rail Assessment" was be completed for every resident who uses bed rails, on admission, readmission, with a significant change and when a request to have a bed rail is made. [s. 15. (1) (a)]

2. On three different dates during the inspection, Inspector #577 observed elevated bed rails in place for resident #005.

The Inspector conducted an interview with PSW #107 and they reported that resident #005 used bed rails.

The Inspector conducted an interview with PSW #108 and they reported that resident #005 used bed rails.

A review of the "Bed Entrapment Prevention program: direct care staff procedure", found that page one indicated, "if the care plan requires the bed rails to be in the down position, the direct care staff must consult with the registered staff and an assessment must be completed (refer to assessment form)".

Inspector #577 reviewed the clinical record for resident #005 and a completed bed rail assessment form was not located.

Inspector #577 conducted an interview with RN #109 and they stated that the unit coordinators and therapy staff assessed the residents for the use of bed rails and they were unsure who documents on the "Bed rail Assessment" form and had not seen it on

any resident charts.

Inspector #577 conducted an interview with RPN #116 and they reported that the registered staff assess residents for the use of bed rails and they had not filled out a bed rail assessment form on residents who required bed rails.

Inspector #577 conducted an interview with RPN #117 who reported that registered nurses assess for bed rails and they had never seen the bed rail assessment form.

Inspector conducted an interview with the DOC who confirmed that it was the home's expectation that registered staff fill out the bed rail assessment form on admission and when there is a change in condition, where a resident required bed rails and the form would be kept on chart. They further confirmed that it was expected that resident #005 and any other residents using bed rails, have this assessment form filled completed. [s. 15. (1) (a)]

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 that ensures that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #7: 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, a person who had 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: 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.

A Critical Incident System (CIS) report was submitted to the Director to report alleged abuse of resident #030 by PSW #104 on a particular day.

The CIS was submitted on a particular day, however the incident actually occurred four days earlier than when the CIS was reported to the Director.

Inspector #617 reviewed the home's investigation notes which indicated the incident was reported to the RN but not when it was reported to the Director of Care (DOC).

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy titled, "Abuse and Neglect Zero Tolerance-Administration Procedure", which identified that upon having received a report of suspected abuse or neglect of a resident the procedure to notify the Director was indicated.

Inspector #617 interviewed the DOC, and they reported that the RN reported the incident

to them on the day of the incident, and was instructed to call the action line. However there was no indication that the action line was notified on that same day. [s. 24. (1)]

2. The licensee has failed to ensure that, a person who had 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: 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.

Inspector #625 reviewed resident #014's care plan and noted that the that staff were to provide nursing care in teams at all times to prevent accusations by the resident and or family.

A review of resident #014's health care record identified a corresponding progress note entered in the fall of 2014, by RN #121 that detailed a discussion where the resident and their spouse informed the RN of allegations of verbal abuse, neglect, physical abuse and emotional abuse.

During an interview with Inspector #625, the DOC stated that they had not been notified of any of the concerns documented with respect to the alleged staff mistreatment of the resident or the allegations of abuse made, but should have been. The DOC confirmed that the home had not reported the allegations of abuse to the Director. [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 that ensures 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: 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labeled within 48 hours of admission and of acquiring, in the case of new items.

Observations made on on the units during a walk though of care areas by Inspectors #577 and #625, revealed unlabeled and used resident personal items:
- Tub Room contained a used brush soiled with debris and a comb with hairs on it;
- Tub Room contained a brush with hair and debris on it;
- Room contained a used electric razor with hair debris;
- Tub Room contained a brown comb with debris and hair on it;
- Shower Room contained a pink comb with debris on it;
- Tub Room contained an unlabeled brush soiled with debris;
- Tub Room contained two black combs and a red comb that were soiled with debris and hair, a black brush soiled with hair and debris;

During an interview with Inspectors #577 and #625, RPN #123 stated that brushes and combs should not be used for multiple residents. The RPN confirmed that these resident items should be labeled.

On another day during the inspection, Inspector #625 observed two unlabeled upper dentures, one unlabeled lower denture and four pairs of glasses in the chart room behind one of the units nursing station. [s. 37. (1) (a)]

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 that ensures that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labeled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition and hydration programs included, a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

Inspector #196 reviewed the weight record binder for documented weights on residents. The following residents did not have a monthly weights documented:

- resident #021's last weight was recorded in November 2015
- resident #018 did not have a weight recorded in December 2015
- resident #019's last weight was recorded in November 2015

Inspector #196 and RN #122 reviewed the weight record binder and the Goldcare computer program and determined that the above three listed residents did not have a weight done or documented in December 2015. [s. 68. (2) (e) (i)]

2. Inspector #625 reviewed resident #020's health care records and the weight documentation for the months July, August, September, October, November and December 2015 were not recorded.

Inspector #625 reviewed resident #034's health care records and the weight documentation for May and September 2015 was not recorded.

Inspector #625 reviewed resident #035's health care records and the weight documentation for the months of May, August, September and October 2015 was not recorded.

Inspector #625 reviewed resident #011's health care records and the weight documentation for the months of April and October 2015 was not recorded.

During an interview on January 8, 2016, with Inspector #625, the RD stated that monthly weights were not always completed and identified resident #036 as not having weights documented in August and September 2015. [s. 68. (2) (e) (i)]

3. The licensee has failed to ensure that the nutrition and hydration programs included, a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

Inspector #196 reviewed the health care records for the following residents and noted that annual heights had not been documented.

- resident #037's last height was documented in December 2014
- resident #021's last height was documented in March 2014

- resident #038's last height was documented in August 2013
- resident #039's last height was documented in October 2014
- resident #040's last height was documented in July 2012
- resident #018's last height was documented in September 2014

Inspector #196 conducted an interview with RN #122 and they confirmed that the home did not take annual heights on residents and that they are only done at the time of admission to the home.

During an interview with Inspector #625, the RD stated that resident heights should be taken on admission and annually and documented in the resident's health care record under vital signs. The RD stated they use the height to calculate resident BMIs and, if the height is outdated, the RD used the outdated value to calculate the BMI. [s. 68. (2) (e) (ii)]

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 that ensures that the the nutrition and hydration programs include, a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter and the body mass index and height of residents upon admission and annually thereafter, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually

relating to the following:
- Residents' Bill of Rights
- Home's policy to promote zero tolerance of abuse and neglect of residents
- Duty to make mandatory reports under section 24
- Whistle-blowing protections.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy titled, "Abuse and Neglect Zero Tolerance". The policy regarding staff retraining identified that:

-all staff must receive training on hire and annually thereafter on the Resident's Bill of Rights including the power imbalance between staff and residents and the potential for abuse and neglect by those in a position of power and responsibility for resident care
-all staff must receive training on Mandatory Reporting requirements on hire and annually thereafter
-all staff must receive training on Whistle Blower Protection Policy on hire and annually thereafter

Inspector #617 reviewed the training records for PSW #104 which identified that their last recorded date of annual training in Resident Bill of Rights, Zero Tolerance of Abuse, Whistle Blower and Mandatory Reporting was in the spring of 2013.

During an interview with Inspector #617, the DOC confirmed that PSW #104, had not had retraining, as required, since spring of 2013. [s. 76. (4)]

2. Inspector #577 conducted an interview with PSW #105 who reported that they had not received any training related to abuse.

The Inspector conducted an interview with RPN #103 who reported that they had not received any training related to abuse.

The Inspector reviewed the abuse training records for 2015, for all staff and the records identified the following:

-Zero tolerance for Abuse and Neglect, 50 of 206 or 24.2 per cent, of staff members, did not receive the training
-Whistle Blowing Protection policy, 93 of 206 or 45 per cent, of staff members, did not receive the training
-Residents' Bill of Rights, 93 of 206 or 45 per cent, of staff members, did not receive the

training

The Inspector conducted an interview with the DOC, and they confirmed that not all staff in the home had received the required retraining on abuse and reported that the training records were correct. In addition, the DOC reported to the Inspector that it was the home's expectation that all staff receive training and retraining in the areas of abuse. [s. 76. (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 that ensures all staff who have received training as required, receive retraining in those areas annually, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee had failed to ensure that the Residents' Bill of Rights was posted and

communicated in French.

On January 4, 2016, the Inspector observed that there was no posting in the home of the Residents' Bill of Rights posted in French.

During an interview with the DOC, they confirmed that there was not a posting in the home of the Residents' Bill of Rights posted in French. [s. 79. (3) (a)]

2. The licensee had failed to ensure that the long-term care home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

On January 4, 2016, the Inspector observed that there was no posting in the home for the policy to promote zero tolerance of abuse and neglect of residents.

During an interview with the DOC, they confirmed that there was not a posting in the home for the policy to promote zero tolerance of abuse and neglect of residents. [s. 79. (3) (c)]

3. The licensee had failed to ensure that the home's policy to minimize the restraining of residents and how to obtain a copy of the policy was not posted in the home.

On January 4, 2016, the Inspector observed that there was no posting in the home for the policy to minimize the restraining of residents, and how a copy of the policy can be obtained.

During an interview with the DOC, they confirmed that there was not a posting in the home for the policy to minimize the restraining of residents, and how a copy of the policy can be obtained. [s. 79. (3) (g)]

4. The licensee had failed to ensure that the name and telephone number of the licensee was posted in the home.

On January 4, 2016, the Inspector observed that there was no posting in the home for the name and telephone number of the licensee.

During an interview with the DOC, they confirmed that there was no posting in the home for the name and telephone number of the licensee. [s. 79. (3) (h)]

5. The licensee had failed to ensure that the measures to be taken in case of fire were posted in the home.

On January 4, 2016, the Inspector observed that there was no posting in the home of the measures to be taken in case of fire.

During an interview with the DOC, they confirmed that there was no posting in the home of the measures to be taken in case of fire. [s. 79. (3) (i)]

6. The licensee had failed to ensure that an explanation of evacuation procedures were posted in the home.

On January 4, 2016, the Inspector observed no posting in the home for an explanation of evacuation procedures.

During an interview with the DOC, they confirmed that there was no posting in the home of evacuation procedures. [s. 79. (3) (j)]

7. The licensee had failed to ensure that copies of the inspection reports from the last two years were posted in the home.

On January 4, 2016, the Inspector observed that there was no posting in the home for the previous RQI report dated December 15, 2015.

During an interview with the DOC they confirmed that there was not a posting in the home for the previous RQI report. [s. 79. (3) (k)]

8. The licensee has failed to ensure that the orders made by an Inspector or a Director with respect to the home was posted in the home.

On January 4, 2016, the Inspector observed no posting in the home for the previous RQI report with Orders dated December 15, 2015.

During an interview with the DOC, they confirmed that there was no posting in the home for the previous RQI report with Orders. [s. 79. (3) (l)]

9. The licensee had failed to ensure that the most recent minutes of the Residents' Council meetings were posted in the home.

On January 4, 2016, the Inspector observed no posting in the home of the most recent minutes of the Residents' Council meetings.

During an interview with the DOC, they confirmed that there was no posting in the home of the most recent minutes of the Residents' Council meetings. [s. 79. (3) (n)]

10. The licensee had failed to ensure that the most recent minutes of the Family Council meetings were posted in the home.

On January 4, 2016, the Inspector observed no posting in the home for the most recent minutes of the Family Council meetings.

During an interview with the DOC, they confirmed that there was no posting in the home for the most recent minutes of the Family Council meetings. [s. 79. (3) (o)]

11. The licensee had failed to ensure that an explanation of whistle-blowing protections related to retaliation were posted in the home.

On January 4, 2016, the Inspector observed no posting in the home for an explanation of whistle-blowing protections related to retaliation.

During an interview with the DOC, they confirmed that there was no posting in the home of the explanation of whistle-blowing protections related to retaliation. [s. 79. (3) (p)]

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 that ensures the Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the home's policy to minimize the restraining of residents was posted and communicated, and how a copy of the policy can be obtained, the name and telephone number of the licensee, an explanation of the measures to be taken in case of fire, an explanation of whistle-blowing protections related to retaliation, most recent Family and Resident Council minutes and the required MOHLTC inspection reports are posted and communicated, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' clothing was labeled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

Inspector #625 conducted an interview with PSWs #124, #125 and #126 who stated that labeling of clothing was completed each Friday. They also reported that if a resident was admitted prior to Friday, that some unlabeled clothing would be kept for the resident to wear until the remainder of their clothing could be labeled and returned on the next Friday.

During an interview with Inspector #625, the DOC confirmed that residents' clothing was labeled once weekly, on Fridays. The DOC stated that some residents might have been asked to bring in clothing prior to admission to be labeled. The DOC also stated that newly acquired clothing is labeled on Friday and there is no guarantee that it will be labeled and returned within 48 hours. [s. 89. (1) (a) (ii)]

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 that ensures that residents' clothing is labeled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee shall ensure that every use of a physical device to restrain resident #033 residing in the home, under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee failed to ensure that the following was documented:
5. the person who applied the device and the time of application
6. all assessment, reassessment and monitoring, including the resident's response
7. every release of the device and all repositioning.

On a specific day during the inspection, Inspector #617 observed resident #033 sitting in their wheelchair with a specific type of safety device in place. Inspector #617 reviewed the health care record for resident #033 which included a physician's order for the specific type of safety device, an assessment form which identified the need for the specific type of safety device, dated in 2012, and a consent from the SDM dated in 2015. Resident #003 was assessed as a high risk for falls and continued to need a specific type of safety device for safety and positioning.

The care plan for resident #003 indicated that the specific type of safety device was to be in place at all times for safety and that staff were to check the integrity of the device and reposition every hour as per policy and standards and document.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy titled, "Restraint Minimization Policy-Appendix 2-Types and Considerations for Use of Restraint", which identified that for long term care residents this specific type of safety device was considered a restraint.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy titled, "Direct Care Provider Application of a Restraint Procedure", which identified that the direct care provider was to complete the following procedures:
#1. Review and follow interventions on Care Plan and Restraint Monitoring Record (form #1914).
#2. Apply prescribed restraint as ordered
#3. Check on resident to monitor safety, comfort and position of the restraint at least hourly
#4. Monitor and report any changes in activities, behaviour, circulation, hydration, nutrition, mood, range of motion and socialization or any skin irritations to a Registered staff member.
#5. Undo the restraint every two hours, and as required, reposition the resident.
#6. Document on the Restraint Monitoring Record (form #1914).

Inspector #617 interviewed PSW #133, who reported that resident restraints are to be documented every hour on the Restraint Monitoring Form, regarding the application, removal, and repositioning of the restraint.

Inspector #617 reviewed the “Restraint Monitoring Record” for resident #033 dated for the month of December 2015, which indicated that documentation was missing for the use, release and application, the monitoring and the resident's response of the specific type of safety device, various hours and times on 22 of 31 dates in the month.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy titled, "Direct Care Provider Application of a Restraint Procedure", which identified in procedure #7 that Registered Staff at the beginning of every shift, prior to the application of any restraint must sign the application decision on the resident's medication administration record (MAR).

Inspector #617 interviewed RPN #103, who reported that registered staff were responsible for documenting resident #033's specific type of safety device on the MAR for day, evening and night shift to ensure that it was applied by the PSW.

Inspector #617 reviewed the MAR dated December 2015, specifically December 1 to 24, 2015, for resident #033. A total of 53 out of 72 eight hour shifts, or 74 per cent, did not have documentation by the registered staff to indicate the assessment of the resident. [s. 110. (7)]

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 that ensures that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response and very release of the device and all repositioning, to be implemented voluntarily.

WN #14: 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).

Findings/Faits saillants :

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

On a day during the inspection, Inspector observed a compounded prescription cream on resident #018's night table. The label was dated and the instructions on the label read to apply the cream twice daily for 14 days. The resident reported that they were currently using it.

During an interview, PSW #132 stated that the prescription cream should have been applied for 14 days and not given any longer.

Inspector #625 reviewed resident #018's physician's orders with RPN #115. The RPN confirmed that the compound had been ordered for a two week period and no further orders to extend the duration of the application or its reorder was received.

During an interview with Inspector #625, the DOC stated that the compound should have been sent to drug destruction in early November 2015 after the last application was completed.

Therefore, the prescription compound ordered for use for a period of 14 days continued to be used for numerous days after the ordered end date, without a prescription. [s. 131. (1)]

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

A review of resident #018's chart identified a physician's order for a compounded treatment ointment to be applied twice daily for 14 days.

Resident #018's Medication Administration Records (MARs) for a two month period listed the dates that the ointment was to be applied. The Inspector determined that 14 out of the 28 applications ordered, or 50 per cent, did not have staff signatures to indicate the medication was applied.

During an interview with Inspector #625, the DOC confirmed that the treatment ointment was not administered 14 out of 28 times as recorded on the MARs. [s. 131. (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 that ensures that no drug is used by a resident in the home unless the drug has been prescribed for the resident and that drugs are administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that, when resident #011 was administered any drug, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Inspector #617 reviewed the Riverside Health Care Facilities Incorporated policy titled "Pain Management Program-Registered Nursing Staff Procedure" printed on March 15, 2013, which identified that procedure #7 expected the registered nursing staff to "document the effectiveness of the interventions."

Inspector #617 interviewed RPN #103 and they reported that the medication

administered as needed to residents for pain was to be charted on the residents' Medication Administration Record (MAR) with the time given. The response to the medication given as needed was to be documented on the progress notes. Inspector #617 interviewed the DOC, who clarified that it is the expectation of the registered staff to document the effectiveness of administered analgesic for pain in the progress notes.

Inspector #617 reviewed the health care record for resident #033. These included the MAR dated for a particular month in 2015, and progress notes dated from this same time, which indicated that resident #033 was administered analgesia for complaints of pain on 25 days in that month in 2015. The effectiveness of this medication was not documented in the progress notes for the administration dates on four occasions. [s. 134. (a)]

2. The home's policy "Pain Management Program Registered Nursing Staff Procedure" stated that registered nursing staff will implement strategies to effectively manage pain, including pharmacological interventions, and will document the effectiveness of the interventions.

Inspector #625 reviewed resident #011's care plan regarding "Pain" that stated that staff were to administer analgesia, regular and as needed, documenting the time given and the effectiveness of the medication.

Inspector #625 reviewed resident #011's MAR for a particular month in 2015, which indicated that on one day, the resident was administered analgesia as per the medical directive.

A review of resident's health care record identified a progress note entered for that day, stated that resident #011 had verbalized pain and was administered analgesia, as per the medical directive. The effectiveness of the analgesia administered on that day was not documented.

During an interview with Inspector #625, the DOC stated that documentation of the effectiveness of prn (as needed) medications should be completed by registered nursing staff in the GoldCare computer program. [s. 134. (a)]

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 that ensures that, when residents are administered any drug, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following: together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act.

On January 4, 2015, the Inspector observed that there was no posting in the home of an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to residents.

During an interview with the DOC, they confirmed that there was not a posting in the home of an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to residents. [s. 225. (1) 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 that ensures the explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to residents is posted in the home, to be implemented voluntarily.

WN #17: 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. The licensee failed to ensure that all staff participate in the implementation of the infection and prevention control program, specifically hand hygiene.

On a day during the inspection, Inspector #625 observed RPN #112 obtain a blood glucose reading from, and an injection to, resident #017 in their room. RPN #112 did not perform hand hygiene before or after these activities.

Inspector #625 asked RPN #112 about the performance of hand hygiene. The RPN stated that staff are expected to perform hand hygiene before and after administering medications and that hand hygiene should have been completed before and after administering a injection to resident #017. RPN #112 showed Inspector a container of hand sanitizer on the medication cart for this purpose.

During an interview with Inspector #625, the Director of Care (DOC) stated that staff were expected to perform hand hygiene as per the "4 Moments of Hand Hygiene" identified in the home's "Hand Hygiene Policy" effective March 31, 2015. The DOC indicated that staff are required to perform hand hygiene before and after patient contact, including the administration of injection medication.

The home's "Hand Hygiene Policy" effective March 31, 2015, listed the indication for performing hand hygiene as before initial contact with the resident or the resident's environment, before aseptic procedure, after body fluid exposure, and after resident environment contact. [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 that ensures that all staff participate in the implementation of the program, specifically hand hygiene, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On a day during the inspection, Inspector #577 observed resident #004's and resident #006's wheelchair cushions to be soiled and stained with food debris.

On three other days, Inspector observed resident #001's wheels on their wheelchair to be unclean and stained with food.

Inspector conducted an interview PSW #120 and they reported that it was the responsibility of the night staff to clean resident's wheelchairs, wheelchair cushions and walkers on the residents first bath day of the week.

An interview with RPN #103 reported that it was the responsibility of the night staff to clean resident's wheelchairs, wheelchair cushions and walkers on the resident's first bath day of the week.

A review of the daily care record for each resident revealed the inspecting and cleaning of residents personal items and residents rooms.

An interview with the DOC confirmed that it was the expectation of the home that the cleaning of residents wheelchairs, wheelchair cushions and walkers be performed by the night staff, according to residents first bath day of the week. [s. 15. (2) (a)]

WN #19: 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 failed to ensure that the home was equipped with a resident-staff communication and response system that, was on at all times.

Inspector #577 observed on two occasions, the call bell at the bedside in a resident room not activate when pushed.

Inspector reported to PSW #120 that the bedside call bell in this resident room was not in working order. PSW #120 confirmed that call bell did not activate when pushed and would submit a request to maintenance. [s. 17. (1) (b)]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 70. Administrator

Specifically failed to comply with the following:

s. 70. (1) Every licensee of a long-term care home shall ensure that the home has an Administrator. 2007, c. 8, s. 70. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had an Administrator.

A complaint was made to the Director which indicated that the home's Administrator was no longer working at the home as of Thursday July 18, 2015.

During an interview with Inspector #625, the DOC stated that there was a period of time when the Administrator position was vacant. The DOC consulted with Human Resources and confirmed that the Administrator position was vacant from June 19, 2015, to June 24, 2015. [s. 70. (1)]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 71. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the long-term care home has a Director of Nursing and Personal Care. 2007, c. 8, s. 71. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a Director of Nursing and Personal Care.

On June 20, 2015, a complaint had been brought forward to the Director which indicated that the home had not had a Director of Nursing working in that position since April 2015.

During an interview with Inspector #625, the current Director of Care (DOC) stated that the DOC position had been vacant from April 2015 to November 2, 2015. The DOC further confirmed with the Human Resources Department that the DOC position had been vacant from April 15, 2015 to November 2, 2015. [s. 71. (1)]

WN #22: 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 licensee has failed to ensure that procedures were developed and implemented to ensure that, all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

Inspector #196 observed the washroom sinks in resident two resident rooms to be eroded and have visual cracks in the bowl at the drain.

The Inspector conducted an interview with Maintenance #118 and they reported that some of the resident washroom sinks had been replaced as they were not repairable.

The Inspector conducted an interview with a manager and they reported that the housekeeping or nursing staff would notify the maintenance department of concerns with washroom sinks as the maintenance department staff do not conduct audits of this area. They confirmed that the sinks in two particular resident rooms had visual cracks in the bowl at the drain after observations were made in the presence of the Inspector and confirmed that the sink in one resident washroom had some chipped material and needed to be replaced. [s. 90. (2) (d)]

WN #23: 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 that a report to the Director included a description of the individuals involved in the incident, specifically the names of any staff members who were present during the incident.

A Critical Incident System report was submitted to the Director in regard to reported neglect of resident #031 when the resident sustained an injury as a result of the provision of care.

Inspector #617 reviewed the home's investigation notes which indicated that RPN #136 was present during the incident, but was not identified in the submitted original or amended reports. [s. 104. (1) 2.]

Issued on this 15th day of February, 2016

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), DEBBIE WARPULA (577), KATHERINE BARCA (625), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2016_246196_0001
Log No. / Registre no:	034906-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 14, 2016
Licensee / Titulaire de permis :	RIVERSIDE HEALTH CARE FACILITIES, INC. 110 VICTORIA AVENUE, FORT FRANCES, ON, P9A-2B7
LTC Home / Foyer de SLD :	RAINYCREST 550 OSBORNE STREET, FORT FRANCES, ON, P9A-3T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Emily Bosma

To RIVERSIDE HEALTH CARE FACILITIES, INC., 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)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the policy and procedure for medical directives, narcotic counts and medication checks is complied with.

Grounds / Motifs :

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

Inspector #625 reviewed the medical directives #RCS F-80-3 which listed types of medication and for what purpose, dosages, route of administration and the duration of the medication administration.

The home's policy "New Physician Orders" stated that all medication orders should specify quantities and/or duration of therapy for all medications ordered, medication orders should be transcribed onto the MAR sheet, and lines should be drawn through boxes on the MAR to the date and time the first dose was given.

(A) A review of resident #011's December 2015 MAR identified a handwritten entry for one of the medications listed on the medical directives, which was initialed as administered on a specific date that month.

During an interview with Inspector #625, RPN #110 stated that orders processed by staff should contain the date and time the entry was placed on the MAR, the

signature of the staff member who entered it on the MAR, and the correct dose ordered.

During an interview with Inspector #625, the DOC stated that orders processed by staff should contain the signature and date the medication was placed on the MAR, the duration of the order, lines drawn through the dates prior to and after the order duration, and the dose that was administered.

The entry on resident #011's December 2015 MAR did not contain the signature of the staff member processing the order onto the MAR, did not contain the date the medication was placed on the MAR, did not accurately transcribe the order including the duration, frequency, route, dose range, and did not have lines drawn to indicate the start and end dates of the medication.

(B) A review of resident #016's December 2015 MAR identified affixed labels for two different medications as listed in the medical directives.

During an interview with Inspector #625, RPN #110 stated that processing of the orders onto the MAR required the signature, date and time processed by staff, which the RPN stated were missing.

During an interview with Inspector #625, the DOC stated that the processing of the orders onto the MAR should contain the signature and date the medication was placed on the MAR, lines drawn through the dates prior to the initial dose being administered and after the 72 and 48 hour durations of the orders ended, which the DOC stated were missing.

The entry on resident #016's December 2015 MAR did not contain the signature of the staff member processing the order onto the MAR, did not contain the date or time the medication was placed on the MAR, and did not have lines drawn to indicated the start and end dates of the medications.

(C) A review of resident #015's September 2015 MAR identified an affixed label for one of the medications as listed on the medical directives.

During an interview with Inspector #625, RPN #110 stated that processing of the orders onto the MAR required the signature, date and time processed by staff, which the RPN stated were missing.

During an interview with Inspector #625, the DOC stated that the processing of the orders onto the MAR should contain the signature and date the medication was placed on the MAR, lines drawn through the dates prior to the initial dose being administered and after the 48 hour durations of the orders ended.

The entry on resident #015's September 2015 MAR did not contain the signature of the staff member processing the order onto the MAR, did not contain the date or time the medication was placed on the MAR, and did not have lines drawn to indicated the start and end dates of the medication.

(D) A review of resident #015's September 2015 MAR identified a handwritten entry for a medicine as listed on the medical directives, signed as administered on a specific day that month.

During an interview with Inspector #625, RPN #110 stated that processing of the orders onto the MAR required the signature, date and time processed by staff, the dose, time administered and identification that it was a medical directive, which the RPN stated were missing.

During an interview with Inspector #625, the DOC stated that the processing of the orders onto the MAR should contain the signature and date the medication was placed on the MAR, lines drawn through the dates prior to the initial dose being administered and after the 72 hour duration of the orders ended, the dose range ordered, the frequency and route of administration, and that the order was a medical directive, all of which the DOC identified were missing. The DOC also identified that the dose and time of medication administration were not recorded on the MAR when it was administered.

The entry on resident #015's September 2015 MAR did not contain the signature of the staff member processing the order onto the MAR, did not contain the date or time the medication was placed on the MAR, did not have lines drawn to indicate the start and end dates of the medication, did not list the frequency and route of administration or that the order was a medical directive. In addition, staff did not record on the MAR the dose and time of the medication administered on a specific day in September 2015.

(E) A review of resident #015's October 2015 MAR identified a handwritten entry for the administration of two doses of medicine, as per the medical directive, on two consecutive days in that month.

During an interview with Inspector #625, RPN #110 stated that processing of the orders onto the MAR required the signature, date and time processed by staff, which the RPN stated were missing.

During an interview with Inspector #625, the DOC stated that the processing of the orders onto the MAR should contain the signature and date the medication was placed on the MAR, lines drawn through the dates prior to the initial dose being administered and after the 72 hour duration of the orders ended, the dose administered on the two days, all of which the DOC identified were missing.

The entry on resident #015's October 2015 MAR did not contain the signature of the staff member processing the order onto the MAR, did not contain the date or time the medication was placed on the MAR, did not have lines drawn to indicated the start and end dates of the medication and did not identify the dose administered on the two specific days.
(625)

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

(A) The home's policy "Narcotic Counts Procedure" stated that the "Narcotic/Controlled Drug Record" should be signed once the count conducted by two registered nursing staff is completed.

During the inspection, on a particular day, at approximately 1100 hrs, a review of the narcotic and controlled drug count was completed by Inspector #625. The Inspector noted that the count conducted at 0630hrs on the "Narcotic/Controlled Drug Record" for one of the units, for scheduled and prn (as needed) medications, had been signed for by one registered staff member, not two as required by the policy. RPN #112 stated that they had not yet signed for the count that had been completed four hours earlier, but reported they should have signed at the time of the count.

During an interview with Inspector #625, the DOC reviewed the "Narcotic/Controlled Drug Record" and stated that both registered nursing staff members should have signed the count at that time of completion.

(B) The home's policy "Managing Narcotic/Controlled Drugs Procedure" stated

that, when administering narcotic or controlled drug, the registered nursing staff should enter the time of administration, enter the remaining amount of the drug left, sign for administration in the signature area and, if more than one drug is administered to more than one resident on the same medication pass, one line should be used to document all drugs administered during the medication pass.

A review of the narcotic and controlled drug count was completed by Inspector #625. The number of medications present, differed from the values recorded on the "Narcotic/Controlled Drug Record" for one of the units, for both the scheduled and prn (as needed) records. Inspector noted that the last entries on both sheets were the count conducted that day at 0630hrs by registered nursing staff.

During an interview with Inspector #625, RPN #112 stated that they had administered scheduled narcotics and controlled medications during the morning medication pass to multiple residents which they had not recorded on the "Narcotic/Controlled Drug Record" for scheduled medications. RPN #112 also stated that they had administered two controlled medications which the RPN had not yet deducted from the "Narcotic/Controlled Drug Record" for prn medications. RPN #112 stated that they were required to sign for the narcotic and controlled medications at the times they had been administered to the residents but had not done so.

During an interview with Inspector #625, the DOC reviewed the count sheets and stated that registered nursing staff are required to sign for each narcotic or controlled medication administered on the sheets as soon after each individual administration as possible. [s. 8. (1) (b)]
(625)

3. 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 policy "Medication Double Check Policy" effective July 29, 2015, stated that an independent double check is required prior to the administration of high alert medications.

Inspector #625 reviewed resident #017's January 2016 MAR and found that 28 out of a required 35 initials, indicating an independent second check occurred, were not signed for. RPN #112 stated that the independent second checks had

not been completed for a high alert medication administration where the second check was not signed for on the MAR. In addition, RPN #112 indicated that the second check for the high alert medication they administered that morning had not been done and the MAR reflected this as there was no initial for the morning high alert medication check.

During an interview with Inspector #625, the DOC stated that this particular medication was a high alert medication and that policy required an independent double check of the medication and should be signed for by both staff in the MAR. The DOC reviewed the January 2016 MAR for resident #017 and counted 28 out of 35 independent double checks were not signed for. The DOC stated that not signing for check indicated the check was not completed. [s. 8. (1) (b)]

(625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 11, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 1. A change of 5 per cent of body weight, or more, over one month.

The licensee shall:

(A) provide education to the registered staff regarding notification of the RD of significant weight changes in residents.

(B) develop and implement a process that ensures that residents in the home with weight changes of five per cent of body weight, over one month, are assessed by the RD.

Grounds / Motifs :

1. The licensee had failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: 1. A change of 5 per cent of body weight, or more, over one month.

Inspector #577 reviewed the health care records for resident #005. The weight record identified that over an approximate one month period, the resident had a weight change of five per cent or more of body weight. A review of the dietary assessments completed by the Registered Dietitian (RD) revealed that an admission assessment was completed the day prior to the documentation of the resident's weight, and a quarterly assessment was dated just over one month later.

The Inspector conducted an interview with the RD who reported that the Goldcare computer program, generates an email notification when there is a weight loss and they could not confirm whether they received a notification through Goldcare. They confirmed that the weight change was considered a five per cent weight change and they did not assess for the resident's weight change in May 2015.

Inspector #577 conducted an interview with RN #106 and they reported that they could not confirm whether they had sent a referral to the RD in the month of resident #005's weight change.

Inspector #577 conducted an interview with the DOC and they confirmed that it was the home's expectation that the RD assess residents on admission, quarterly and with significant changes, and that the Goldcare computer program would generate an email notification regarding a resident's weight loss. The DOC further confirmed that it was expected that registered staff also email the RD for concerns and the RD would assess residents for weight change and specifically a five per cent weight change for resident #005. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

(577)

2. The licensee had failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: 1. A change of 5 per cent of body weight, or more, over one month.

Inspector reviewed the health care records for resident #003. The weight record identified that over an approximate one month period, the resident had a weight

change of five per cent or more of their body weight. A review of dietary assessments completed by the RD revealed an admission assessment completed in early summer 2015, and a quarterly assessment done approximately two and a half months later and again three months later.

Inspector #577 conducted an interview with the RD and they reported that the Goldcare computer program, generates an email notification when there is a weight loss and they could not confirm whether they received a notification through Goldcare. They confirmed that resident #003 had a weight change greater than five per cent in one month and they did not assess the resident's weight change.

Inspector #577 conducted an interview with the DOC and they confirmed that it was the home's expectation that the RD assess residents on admission, quarterly and with significant changes, and that the Goldcare computer program generates an email notification regarding resident's weight loss. They further confirmed that it was expected that registered staff also email the RD for concerns and the RD would assess residents for weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 11, 2016

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 14th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

Service Area Office /
Bureau régional de services : Sudbury Service Area Office