Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 4, 2019	2018_783742_0001	024408-18, 026136-18, 026137-18, 028511-18	Critical Incident System

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

SHARON GOERTZEN (742), DEBBIE WARPULA (577)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 3 - 7, and 10 - 14, 2018.

The following intakes were inspected during this Critical Incident System Inspection which occurred concurrently with Resident Quality Inspection #2018_768693_0016

-One Follow Up log for compliance order (CO) #001, issued during inspection #2018_655679_0020, regarding s.23 related to not immediately investigating allegations of abuse and neglect;
-One Follow Up log for compliance order (CO) #002, issued during inspection #2018_655679_0020, regarding s.24 related to not immediately reporting allegations of abuse and neglect.
-Two Critical Incidents (CI's), related to abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Acting Administrators, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Support Worker, Utilization Coordinator (UC), Pharmacist, and Registered Dietician (RD).

The inspectors(s) also observed staff to resident interactions, observed the provision of care and services to residents, reviewed relevant health records, as well as licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

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

4 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #001	2018_655679_0020	742
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2018_655679_0020	742

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
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 the following rights of residents were fully respected

and promoted: Every resident has the right to be protected from abuse.

Under O. Reg. 79/10, emotional abuse is defined as "any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

A Critical Incident System (CIS) report was received by the Director, concerning alleged staff to resident abuse. The report indicated that resident Personal Support Worker (PSW) #104 abused resident #001,which resulted in the resident sustaining an injury.

A review of resident #001's most current care plan, indicated that staff were to approach and speak in a calm manner; divert attention; remove from the situation and take to an alternate location as needed; and redirect and discourage from entering other residents' rooms.

Under the nursing focus within the plan of care, interventions indicated that staff were to use communication techniques which would facilitate optimal interaction; use their preferred name to reinforce name recognition, use brief, consistent, simple, directive sentences, and use plain terms.

A review of the home's policy, "Zero Tolerance of Abuse and Neglect– ORG-II-PAT-10", effective date April 11, 2018, indicated that the home was committed to providing an environment of zero tolerance of abuse or neglect of residents by any person.

During an interview with PSW #104, they reported to Inspector #742 that they were in another resident's room when resident #001 had attempted to enter the room. They further reported that they told resident #001 to leave the room and they had attempted to close the door to prevent the resident from entering.

During an interview with Support Worker #105, they reported to the Inspector that they observed resident #001 follow PSW #104 into another resident's room. They reported that PSW #104 interacted inappropriately with resident #001, and pushed the door against resident #001 multiple times to prevent them from entering the room.

During an Interview with Director of Care (DOC) #108, they confirmed that abuse had occurred by PSW #104 towards resident #001. [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 to ensure that residents rights are fully respected and promoted: Every resident has the right to be protected from abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A CIS report was received by the Director, concerning alleged neglect of resident #002. The report indicated that there was an allegation that the home had neglected the resident's nutritional needs over multiple days, and had not requested a physician's consult. The report further indicated that the resident had been refusing their medications

on a regular basis and had been hospitalized.

Additional non-compliance to support this finding is reflected in WN #3, related to O.Reg. 79/10, s. 8 (1).

A record review of resident #002's health care records revealed that the resident had multiple hospitalizations in the fall of 2018, for similar health conditions.

A review of the progress notes and MARS revealed that resident #002 had refused a prescribed medication on several occasions over a period of time.

During a review of the progress notes over multiple months, there was no indication that the Physician was made aware of the resident refusing their medications.

Inspector #742 reviewed resident 002's care plan, last revised in the fall of 2018, which revealed under a nursing focus the resident refused to take their prescribed medications; resident had been refusing to take medications on a regular basis. Interventions related to facilitating medication administration for the resident were listed.

During a review of resident #002's health care records, Inspector #742 found a hand written note by the Physician on letter head- with no date. The note indicated to nursing staff that a prescription for medication was prescribed daily, but if resident refused, accumulate the refused medication tablets and offer it the next day. For instance, if they refuse for multiple days, they could be given multiple days at once.

A review of the Physician orders and the MAR did not indicate that the written note by the Physician had been transcribed.

A record review of the physician's discharge summary from hospital, dated in the fall of 2018, indicated that they had recommended that nursing staff accumulate every missed dose of medication, day by day, when the resident had been refusing their medication; and when the resident would respond to taking their medication, staff could administer the entire catch-up dose all at once.

A review of the home's policy, "Drug Distribution – 02-02-10" updated September 1, 2014, indicated that orders were to be faxed or sent by digital pen to the pharmacy. The pharmacy required a fax of the original Physicians order form for any prescription orders including new, discontinued or change of directions.

During an interview with Registered Practical Nurse (RPN) #109, they reported that resident #002 had almost always refused their medication and the medication administration times had been changed multiple times to address this.

During an interview with the Utilization Coordinator (UC) #110, they confirmed that resident #002 had been refusing all of their medications over multiple months in the fall of 2018, and they could not confirm that the Physician was notified. Additionally UC #110 and RN #111 could not confirm that the hand written note which had given staff directions for the administration of medication, was given as per Physician's directions, nor processed.

During an interview with pharmacist #112, they confirmed that they had received an order for medication on particular day in the summer, and nothing thereafter.

During an interview with DOC #108, they confirmed during a review of the progress notes and MARS with Inspector #742, that resident #002 had refused their medication and that there were no progress notes which indicated that the Physician was made aware. They reported that the Physician was aware that the resident had been refusing their medication. They reported that staff needed to document communication with the Physician. They further confirmed that staff should have transcribed the hand written Physician's note onto an order sheet and that staff had not followed the drug distribution policy. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A CIS report was received by the Director, concerning alleged neglect of resident #002. The report indicated that there was an allegation that the home had neglected the resident's nutritional needs over multiple days, and had not requested a physician's consult. The report further indicated that in a specific month in the fall of 2018, the resident had been refusing food, fluids, medication, and personal care.

Inspector #742 conducted a record review of resident #002's care plan which revealed the following nursing interventions related to their nutritional needs:

- staff were to record on the dietary intake sheet; and
- staff were to monitor the resident's fluid balance.

Inspector #742 conducted a record review of resident #002's nutritional intake flow sheets over a five month period, which revealed inconsistencies as follows:

- meal percentages were recorded for 1/90 meals or 1%, and the fluid balances were recorded for 50/90 or 55 percent (%) of all meals;
- meal percentages were recorded for 1/93 meals or 1%, and the fluid balances were recorded for 35/93 or 37% of all meals;
- meal percentages were recorded for 6/93 or 6% of all meals; and the fluid balances were recorded for 32/93 or 34% of all meals;
- meal percentages were not recorded for 61/61 meals or 100%, and the fluid balances were recorded for 20/61 or 32% of all meals;
- meal percentages were not recorded for 63/63 meals or 100%, and the fluid balances were recorded for 18/63 or 28% of all meals.

A review of the progress notes documented by the previous Food Service Supervisor (FSS) #113, dated in the spring of 2018, indicated that they had received a message from the nursing staff that the resident's intake was poor. The progress note indicated that the nutrition intake flow sheets were not being completed; the Registered Dietician (RD) was aware and was to assess the resident, and the DOC was informed of the incomplete nutrition intake flowsheets.

A review of the home's policy, "Nutrition and Hydration Program Procedure Direct care Staff Procedure - ORG- II-RES-10.3" effective April 18, 2018, indicated that staff were to record or report the resident's diet and fluid intake following each meal, and at the end of each shift.

During an interview with PSW #114, they reported to Inspector #742 that PSWs were responsible to have documented the resident's percentage of meal intakes and oral fluid intakes on the nutritional intake flow sheet. They further confirmed that the documentation on the flow sheets were inconsistent, and lacking many meal and fluid intakes.

During an interview with RPN #109, they reported that PSWs and RPNs were responsible to have documented the resident's meal intakes and oral fluid intakes on the nutritional intake flow sheet. They further confirmed the documentation on the nutritional intake record was inconsistent.

In an interview with DOC #108, they reported to the Inspector that the staff member who provided the meal to the resident would have been responsible to have documented the oral intake on the nutritional flow sheet. Together with the Inspector, the nutritional flow sheets were reviewed and the DOC further confirmed that the documentation was inconsistent. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, 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; and to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the LTCHA, 2007 or O.Reg. 79/10 required the licensee of the long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy,

protocol, procedure, or system, was complied with.

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

A CIS report was received by the Director concerning alleged neglect of resident #002. The report indicated that for a period of time in the fall of 2018, the resident had been refusing interventions in various care areas.

During a review of resident #002's health care records, Inspector #742 found a hand written note by the Physician on letter head- with no date. The note indicated to nursing staff that a prescription for medication was prescribed at a specific frequency, but if resident refused, accumulate the refused medication tablets and offer it the next day. For instance, if they refuse for multiple days, they could be given multiple tablets all at once.

A review of the Physician orders and MARS did not indicate that the note written by physician was transcribed.

A record review of the Physician's discharge summary from the hospital, indicated that they had recommended that nursing staff administer missed medication doses in a specific manner.

A review of the home's policy, "Drug Distribution – 02-02-10" updated September 1, 2014, indicated that orders were to be faxed or sent by digital pen to pharmacy. Pharmacy required a fax of the original Physician's order form for any prescription orders including new, discontinued or change of directions.

During an interview with RPN #109, they reported that resident #002 had almost always refused their medication and the medication administration times had adjusted multiple times. Further they reported that the Physician had given staff additional instructions to administer medication. They confirmed that they could not recall whether this was ever done.

During an interview with UC #110, they confirmed that resident #002 had been refusing all of their medications over a specific period of time. Additionally UC #110, and RN #111, could not confirm that the hand written note, which had given staff directions for

the administration of specific medication, was given as per Physician's directions, nor processed.

During an interview with Pharmacist #112, they confirmed that they had received an order for prescribed medication on a date in the summer of 2018, and nothing thereafter.

During an interview with DOC #108, they confirmed with Inspector #742 that according to the policy the nursing staff should have faxed the letterhead order to the pharmacy and confirmed that the Drug Distribution policy wasn't being followed. [s. 8. (1)]

WN #4: 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 has failed to ensure that residents with a weight change of five per cent body weight, or more, over one month, were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

A CIS report was received by the Director concerning alleged neglect of resident #002. The report indicated that there was an allegation that the home had neglected the resident's nutritional needs over multiple days, and had not requested a physician's consult. The report further indicated that in a specific month in the fall of 2018, the resident had been refusing interventions in various care areas.

Inspector #742 conducted a record review of resident #002's weights over multiple months, and found a weight change of greater then five percent body weight over one

month in the spring of 2018.

A record review of resident #002's most current care plan indicated the following:

- intakes were inconsistent and they would often refuse meals;
- if the resident refused meals, they would usually eat an alternative food item;
- staff were to provide a nutritional supplement at a specific frequency;
- staff were required to notify the Registered Dietician (RD) of significant weight changes.

A review of the Registered Dietician's quarterly nutrition assessment in the spring of 2018 , indicated that resident #002's nutritional risk remained high, and their weight remained below a healthy range but stable over the last quarter with no significant changes. The resident was to receive meals in a particular manner and a nutritional supplement.

During a record review of the progress notes over multiple months in the spring of 2018, Inspector #742 found no documentation that identified that a referral to the RD was made for the significant weight change, or that the RD was aware, or that an assessment was completed to address the weight change.

A review of the home's policy, "Nutritional Consult Long term care - #ORG-II-RES-10.8" effective April 18, 2018, indicated that the RD was to be consulted with a five percent weight change over one month.

A review of the home's policy, "Resident Refusal to Eat Procedure – #ORG-II-RES-10.5" effective April 18, 2018, indicated that the resident was to be weighed on a monthly basis, and changes in the resident's condition, and weight, were to be reported to the RD.

During an interview with UC #110, they reported to Inspector #742 that resident #002 should have been referred to the RD when there was a significant weight change. They further reported that the RN or UC were responsible for referrals to the RD, via email.

During an interview with the RD, they had reported to the Inspector that resident #002 would refuse meals, but did consume their nutritional supplements. Inspector #742 reviewed the multiple month weight history with the RD and they confirmed that resident #002 had a significant weight change of more then five percent in the spring of 2018. Additionally the RD identified that a referral had not been received from the registered nursing staff for the significant weight change over one month in the spring of 2018, and

should have, in accordance with the home's policy.

During an interview with the DOC, they reported that the UCs were responsible for generating RD referrals, via email referral. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 15th day of January, 2019

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

Original report signed by the inspector.