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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Sep 5, 2014	2014_348143_0014	S –000313-14	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

RAINY RIVER HEALTH CENTRE
114 FOURTH STREET, P.O. BOX 236, RAINY RIVER, ON, P0W-1L0

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

PAUL MILLER (143)

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): August 25th to the 28th, September 3rd to the 5th, 2014.

During the course of the inspection, the inspector(s) spoke with the Director of Care, an attending physician, Registered Nurses, Registered Practical Nurses, Personal Support Workers, dietary staff, the Registered Dietitian, the Food Service Supervisor, maintenance staff, the President of the Family Council, family members and residents.

During the course of the inspection, the inspector(s) completed a tour of the resident home area, observed meal service, observed medication administration, reviewed infection control practices, reviewed policies and procedures and observed resident care and services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The Licensee has failed to comply with Ontario Regulation 79/10 section 9.(1) 1.i by not ensuring that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, kept closed and locked.
On August 25th, 2014 Inspector #143 entered and exited the home, via the main entrance without having to engage a key pad or any other locking device. On August 25th, 2014 the inspector interviewed the Director of Care (DOC) and maintenance staff and was advised by both staff that the front entrance door will only lock if a resident with a wander guard device gets close to the door or when the security system is bypassed between 2000 hours and 0700 hours. The DOC advised the inspector that a purchase order was in place to have work completed by December 2014 to ensure that the front door remains locked at all times. The DOC advised the inspector that no resident had wandered from the home without staff knowledge for the period of time November 28th, 2013 at which time this non compliance was first identified. [s. 9. (1) 1. i.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the front door (main entrance) is kept closed and locked at all times, 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. (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).

Findings/Faits saillants :

1. The licensee has failed to comply with the Long Term Care Homes Act, section 6. (1) (c) by not ensuring that the plan of care sets out clear directions to staff who provide direct care.
A review of Resident #465 most recent MDS assessment completed within the Goldcare program (June 15, 2014) Resident Assessment Protocol Summary indicated that the resident's potential for functional rehabilitation had been adjusted. The resident is no longer able to safely ambulate on his/her own. A review of the plan of care indicated that the resident continues to wander the home. Staff (S)111 confirmed with the inspector that the resident is not able to ambulate on his/her own and no longer wanders. S111 reported to the inspector that the plan of care is required to be updated when the quarterly and annual MDS assessments are completed and at times when resident condition changes. [s. 6. (1) (c)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with the Long Term Care Homes Act section 60(2) by not ensuring that Family Council concerns are responded to in writing within 10 days.
On September 4th, 2014 Inspector #143 conducted a telephone interview with the President of the Family Council. During this interview, a review of the Council meetings indicated that on March 18th, 2013 the Family Council had submitted a written letter indicating a concern about meals. The President of the Family Council reported that the Director of Care had not responded in writing to her in regards to this concern. The President of the Family Council reported that any concerns are addressed on an informal basis and that this issue had been addressed. An interview with the Director of Care on September 4th, 2014 confirmed that the Licensee does not respond in writing to Family Council concerns or recommendations. [s. 60. (2)]

WN #4: 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. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with Ontario Regulation 79/10 section 110. (2) 1. by not ensuring that a physician order for a restraint is obtained.
On a specified date Inspector #143 completed an audit of three residents who require the use of restraints. Resident #468 was observed to have a restraint in place. A review of the physician's orders indicated that an attending physician had ordered a a specific type of restraint for safety and positioning. On a specified date resident #468 was observed with a type of restraint that had not been ordered for the resident. S111 (RPN) confirmed with the inspector that the home did not have an order for the type of restraint applied to resident #468. [s. 110. (2) 1.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents’ Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The Licensee has failed to comply with Ontario Regulation 79/10 section 228.4.i by not maintaining a record that identifies when improvements to the quality of the accommodation, care, services, programs and goods were communicated to the Residents' Council (RC), Family Council (FC) and staff of the home.
Interviews were completed with the President of the Family Council as well as a resident representative of the Resident Council. Both of these individuals identified that the home had communicated to them in an informal manner improvements within the home. The DOC (August 29th, 2014) completed the LTCH Licensee Confirmation Checklist Quality Improvement and indicated a no response to, "does the licensee maintain a record of communication". The DOC reported to the inspector on September 4th, 2014 the quality improvement record does not identify when improvements (matters section 228.4.i) were communicated or how the communication (section 228.4.iii.) occurred. [s. 228. 4.]

Issued on this 9th day of September, 2014

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