Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 25, 2018	2018_703625_0008	026951-17, 029628-17, 003938-18, 007190-18, 007381-18	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

KATHERINE BARCA (625), AMY GEAUVREAU (642), SHEILA CLARK (617)

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): April 17 to 20 and 23 to 27, 2018.

This Critical Incident System (CIS) inspection was conducted to inspect on the following intakes:
- one log related to alleged staff to resident abuse;
- one log related to the fall of a resident that caused an injury where the resident

was taken to hospital and which resulted in a significant change in the resident's health status;
- one log related to alleged neglect; and
- two logs related to an outbreak.

Follow-up inspection # 2018_703625_0007 and Complaint inspection #2018_703625_0009 were conducted concurrently with this CIS inspection.

A finding of non-compliance related to the Long-Term Care Homes Act (LTCHA), 2007, s. 6. (4) (a) identified during this inspection was issued under Complaint inspection report #2018_703625_0009.

A finding of non-compliance related to the LTCHA, 2007, s. 6. (9) 1 identified during this inspection was issued under Follow-up inspection report #2018_703625_0007.

During the course of the inspection, the inspector(s) spoke with residents, families, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Resident Assessment Instrument (RAI) Coordinator, an Infection Control Practitioner (ICP), a Public Health Inspector, representatives from the Ontario Nurses Association, an Administrative Assistant, a Ward Clerk, a Receptionist, a Financial Services employee, a Physiotherapy Assistant (PTA), Physiotherapists (PTs), the Activity Coordinator, the Assistant Director of Care (ADOC), the Director of Resident Care (DOC), the Manager of Maintenance, the Director of Engineering and the Administrator.

The Inspectors conducted daily tours of resident care areas, observed the provision of care and services to residents and observed staff and resident interactions. The Inspectors also reviewed residents' health care records, training records, staffing documents, and licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

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

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident System (CIS) report was submitted to the Director regarding the fall of resident #007 in the winter of 2017. The report indicated that resident #007 fell and sustained an injury that required medical intervention.

During an interview with Inspector #617, resident #007 reported they had fallen and sustained an injury that required medical intervention. The resident reported that after the fall, they were not able to perform a specific activity of daily living that they had engaged in prior to the fall.

A review of the home's policy titled "Post Falls Assessment and Management Registered Nursing Staff Procedure-NUR-F-25" last updated on July 5, 2017, indicated that when a resident had fallen, the nursing staff who discovered or witnessed the fall were to complete the post fall screening tool and fall risk assessment to assist in identifying possible contributing factors. The registered staff were then to submit referrals to appropriate disciplines as indicated by the assessments.

During an interview with RN #113, they reported to Inspector #617 that when registered staff discovered and responded to a resident's fall, they were responsible to complete the "Scott Fall Risk Screening Tool" and the "Post Fall Screen", update the results of these assessments in the resident's care plan, make suggested referrals to the appropriate

disciplines, and communicate any changes to the staff.

A review of resident #007's health care record identified that the post fall assessments, the "Scott Fall Risk Screening Tool" and the "Post Fall Screen", required to be completed for their fall in the winter of 2017, were not present.

During an interview with RN #107, they reported to the Inspector that they had responded to resident #007's fall in the winter of 2017. The RN reviewed the resident's health care record and confirmed that both post fall assessments, the "Scott Fall Risk Screening Tool" and the "Post Fall Screen", had not been completed and were absent.

During an interview with the DOC they confirmed that registered staff had been required to complete the post falls assessment tools after resident #007 fell in the winter of 2017, to determine the causative factors and make any necessary changes to the resident's care plan. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 29th day of May, 2018

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

Original report signed by the inspector.