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
Dec 15, 2014	2014_339579_0016	S-000351-14	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

RAINYCREST
550 OSBORNE STREET FORT FRANCES ON P9A 3T2

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

JANET MCNABB (579), BEVERLEY GELLERT (597), DEBBIE WARPULA (577), JENNIFER LAURICELLA (542)

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): September 15, 16, 17, 18, 22, 23, 24 and 25, 2014.

Ministry of Health logs S-000484-13, 283-14/S-000254-14, 2065-14/S-000316-14, S-000072-14, S-004408-14 and S-000147-14 were also inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, the CEO of the Hospital and the Long Term Care Home, the Director of Resident Care (DOC), the Activation Coordinator, the Dietary Supervisor, (NM), the Manager of Environmental Services, Registered Nursing Staff, Personal Support Workers (PSW), Laundry aids, Dietary aids, human resource staff from the hospital, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

14 WN(s)
6 VPC(s)
1 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. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. This is a follow up to inspection #2013_211106_0034 whereas a compliance order was issued, to meet compliance by May 31st, 2014 to ensure the registered dietitian, who is a member of the staff, is on site for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.
Previously; One Compliance Order (CO) under O. Reg 79/10, s. 74 (2) was issued in May 2013 during inspection #2012_104196_0047 and One Voluntary Plan of Correction (VPC) under O. Reg. 79/10, s. 74 (2) was issued in July 2011.
On September 18th and September 23rd, 2014 Inspectors #579 and #542 interviewed the Administrator and asked for the number of hours that the dietitian had been on site for the months of May, June, July and August 2014. Inspector #579 also asked staff #111 to produce a list or verification of the same request.
The Administrator was able to produce a payroll report that listed the number of hours per these months that the dietitian was on site which were:
May 2014 = 75 hours
June 2014 = 67.5
July 2014 = 67.5
August 2014 = 67.5
The Administrator had identified to inspector #542 that the Long Term Care Home also paid hours for the dietitian to be at the hospital.
Both the Administrator and staff #111 stated that they were "pretty sure" that the dietitian was "close" to meeting the required hours but recognized they have nothing to verify this is happening. The Administrator reported that the dietitian was on vacation and during the course of the inspection there was no dietitian in the home.
The home has the capability of having 164 residents, that translates into the required hours being 82 hours per month that the registered dietitian should be on site.
The licensee has failed to ensure that the Registered Dietitian (or dietitians) who is a member of staff of the home on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. [s. 74. (2)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. In 2014 a Critical Incident (CI) was submitted to the Director. Inspector #542 reviewed the Critical Incident which indicated that resident # 6217 had fallen in their room and sustained a fracture. The CI also indicated that resident #6217 was not cautioned about the risks. Inspector #542 completed a health record review for resident #6217, which noted the resident was independent with their transfers prior to their fall. Inspector #542 interviewed resident #6217 who stated that they fell and sustained a fracture because they were not made aware of the risks. Inspector #542 interviewed the Administrator with regards to this CI. The Administrator informed this Inspector that the Manager of Housekeeping (staff #105) was to have a meeting with the staff. Staff #105 also verified that it is not the normal procedure for the housekeeping staff. (s. 5.)

2. Log #S-000147-14 inspection of a Critical Incident (CI):
Resident #003 was exiting a washroom. They walked out from the privacy wall in front of the bathroom and were struck by a cart that was being pushed down the hall by staff #104. Resident #003 landed on their left elbow and buttocks, then fell onto their back. Resident #003 sustained a superficial abrasion and complained of discomfort. No bruising or abrasions were noted but did have decreased range of motion (ROM). Resident #003 was sent to hospital for assessment and was diagnosed with a fracture. Inspector #597 interviewed resident #003 on Sept 25, 2014 and resident #003 confirmed the details of incident report.
Inspector #597 interviewed staff #104 who reported that they were pushing a tall cart down the main hallway toward the East Side. Staff #104 reported that they cannot see over the cart but looks from side to side as they are pushing the cart from behind. Staff #104 stated that they did not see resident #003.
Staff #105 was interviewed by Inspector #597 regarding this incident and the corresponding corrective action. Staff #105 stated that the privacy screens that were permanently attached to the floor and wall in front of the washroom were removed as a result of this incident.
Corrective action was listed on the CI by the DOC to remind staff to use mirrors, take their time when passing through the hallways of the home, proceed with caution and be aware of surroundings. Inspector #597 was not provided with meeting minutes to verify that this reminder was completed. Only one mirror was noted in the main hallway between West and East wing. It is located high on the wall and set back from where the incident occurred.
The licensee has failed to ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5. [s. 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 to ensure that the home is a safe and secure environment for its residents, specifically related to the washing of the floors in resident's rooms and the delivery of resident's laundry using the laundry carts, to be implemented voluntarily.

WN #3: 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. On September 23, 2014 Inspector #542 reviewed the health care record for resident #6201. Inspector #542 reviewed the progress notes from the Registered Dietitian which indicated that the resident was to receive a protein supplement. Upon review of the most current care plan accessed by the direct care staff, this Inspector was unable to locate this information. Inspector #542 interviewed the Nutrition Manager who was also unable to locate this information on the care plan and agreed that the Registered Dietitian (RD) is the one who ensures that this information is on the specific resident's care plan.

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. [s. 6. (1) (c)]

2. On September 25th, 2014 Inspector #579 interviewed staff #119 about the night pertaining to the phone discussion with the family of resident #004. Staff #119 stated that this was a long time ago. Staff #119 remembered that there were many conversations with the family, by phone, and that resident #004 had been expressing their health care wishes and choices to staff #119 up to this point. Staff #119 remembered calling the doctor about resident #004 and also speaking with a nurse at the local hospital. Staff #119 reported that when the family informed them that they wished to make level of care decisions for the resident at this time, staff #119 informed the family that they could not find the Attorney papers allowing them to act. Staff #119 reported that previously they never had cause to contact family to make resident #004’s health care decisions and were not aware that there were Attorney papers. Staff #119 reported that when they left their shift September 21, 2013 resident #004 was still in the home, as they had chosen. Inspector #579 reviewed the health care record for resident #004 and documentation identified that the family had to fax a copy of the Power of Attorney papers to the home after the phone call with staff #119.
On September 10th, 2014 inspector #579 interviewed one of the Attorney’s for Personal Care (SDM/POAPC) who reported that legal Power of Attorney (POA) documents had been given to the home on resident #004's admission; however, these papers went "missing" from the health record when the Attorney's wanted to act and make health care decisions for resident #004.
Inspector #579 interviewed the DOC who reported that the home found resident #004's Attorney papers had been filed in the wrong health record by mistake. [s. 6. (1) (c)]

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 plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: 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. A complaint log S-00072-14 was submitted to the Director and reviewed by Inspector #542. The complaint was specifically related to the maintenance and housekeeping of the home.
Over the course of the inspection, the Inspectors observed numerous walls/ceilings throughout the home to have either water stains, scratches, scuff marks or to be gouged, requiring painting and repair. Multiple resident rooms and tub/shower rooms were noted to have several holes in the walls exposing the drywall. Inspectors also noted that in several of the resident's rooms the flooring was either stained or rolling up away from the floor. In one of the tub/shower rooms the wall tile was missing in a few areas exposing the drywall and left unclean. Throughout the home, several areas were missing baseboard trim, again exposing the drywall.

The licensee did not ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: 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. Observations of residents' #6145, #6143 and #6138 by Inspectors #579 and #577 were done during Stage 1 of the inspection. The head of the bed of one resident had a gap of approximately 10-12 inches between the top of the mattress and the head board. The bottom of the mattress at the foot of the bed was tight against the foot board. It was also observed multiple times that the residents' beds are pushed up tight against the wall, regardless of railings up or not, and the resident only has access to getting out of the bed from one side.
Inspector #579 interviewed the DOC and Administrator who stated that beds are placed against the wall as part of their zone protection for residents. This practice is not used as a form of restraint and they do keep in mind a residents preference for which side of the bed they prefer to get out on, if able to.
The DOC and Administrator confirmed to Inspector #579 that entrapment zones have been identified but beds have not yet been assessed for entrapment. A new "draft" policy was provided, however, has not been implemented yet.
Inspector #597 interviewed staff #117 who reported to the inspector that beds are against the walls due to space constraints in the home. Side rails used as a restraints are included in the care plan. If they are not included in the care plan, the rails are down when residents are in bed. Almost all beds on unit are Hi/Low beds. Staff #117 stated that "Crash mats" are used with beds in the lowest position with side rails down.
Staff #117 was aware of entrapment zones but reported that a formal assessment has not been completed. Staff #117 was aware of a new policy that the management team is working on and aware that an assessment process is going to be formalized.
The licensee has failed to ensure that 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; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (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). [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #6: 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. On September 25th, 2014, and previously during the course of the inspection, Inspector #579 had been asking the Administrator and DOC for records of Abuse Prevention and Whistle Blowing education provided to all staff and the only records produced to this inspector were documentation lists of the nursing staff having taken this education and no other staff in other departments. The home produced a count of total staff in the home and for 2013 there were 191 staff and currently for 2014 the staff count is 201. On the list for staff having taken the Abuse Recognition and Prevention education in various months of 2013 were 90 of 191 staff names, which are nursing department. The education titled Zero Tolerance for Abuse and Neglect for 2013 had 90 of 191 staff listed as attending, which were all nursing staff. The education titled Whistle Blower Protection Policy also had 90 staff attend in 2013 (47% of total staff, and only nursing staff for all three sessions offered).
The home's Abuse and Neglect Zero Tolerance Policy states that all staff must receive training on hire and annually thereafter on: Residents Bill of Rights, Whistle-blower Protection policy and there is also a statement that all staff are responsible for having knowledge of their role in the prevention of abuse and neglect.
The annual training for 2014 is still underway.
The licensee has failed to 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) [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 to 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, specifically related to Zero tolerance of Abuse and Neglect of residents and Whistle-blowing protection, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. Inspector #577 found expired government stock medication on the East Wing in the medication room cupboard. Specifically, 4 bottles of Metamucil expired April 2014 , 1 bottle of 1% Isopto tears expired March 2014, 1 box of Dulcolax suppositories expired April 30, 2014, and 1 Sodium Chloride 0.9% bottle for injection expired February 1, 2014. Inspector spoke with staff #108 concerning the process for expired medication. Staff #108 reports they would notify the Registered Nurse and inform them that they have expired medication and place prescribed and non-prescribed medication in the locked medication destruction cupboard in the medication room. Inspector #577 reviewed the home's use of the pharmacy (Shoppers Drug Mart) policy for Drug Inventory Management. The policy states that drug destruction will be done monthly, drugs that are to be destroyed and disposed of are to be stored safely and securely. Each nursing station will have a clearly marked storage area for discontinued or outdated medications that is separate from drugs that are available for administration. Inspector #577 interviewed the DOC who confirmed that the licensee does not have a policy or procedure for checking medication expiration dates.
Inspector #577 found prescribed creams 3% LCD in Hyderm 1%, Clotrimaderm cream 1%, Nyaderm cream 100,000 U/G and Clotrimaderm cream 1% with no affixed label indicating expiry dates. Inspector #577 also found gel in a tube with a resident's name written in pen on the tube, that was not legible. Inspector #577 spoke with staff #109 and they reported that prescribed creams should have a separate affixed label with an expiry date attached to the bottle. Inspector #577 reviewed the policy for labeling of prescriptions. The policy states, "All labels must be typed and firmly affixed to containers. Prescription labels must include the expiry date".

The licensee failed to ensure proper medication storage (iv) that complies with manufacturer's instructions for the storage of the drugs;
O. Reg. 79/10, s. 129 (1). [s. 129. (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 to ensure proper medication storage (iv) that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #8: 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. In 2014 a Critical Incident (CI) was submitted to the Director. Inspector #542 reviewed the CI which indicated that resident #6217 had fallen and sustained a fracture. On September 18th, 2014 Inspector #542 completed a health record review for resident #6217 and could not locate a post-fall assessment. On September 24th, 2014 Inspector #542 interviewed staff #124 and was informed that they complete an incident report and they are supposed to use the Post Fall Assessment as a guide but it isn't always done. Inspector #542 was informed by the Director of Care (DOC) that the registered staff previously did complete a Post Fall Assessment, however they were told to include all of the information in the Incident Report instead of completing the Post Fall Assessment form. Inspector #542 reviewed the home's policy and procedure on Falls Prevention and Management that was provided by the DOC which verifies that the staff are to complete the Post Falls Assessment.
The licensee has failed to ensure that when the resident has fallen a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

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. On September 23, 2014, Inspector #579 did a record review for resident #6138 and it was indicated that their height coded for the most recent Minimum Data Set, Resident Assessment Instrument (MDS/RAI) assessment had in the section K calculation, for the resident's body mass index (BMI), a height that had been documented in 2011. There was also a weight result documented in the height column in 2012 of 56.60Kg. The nursing software legend, accessible in section K, states the the BMI is updated from the last recorded height and weight to produce the up to date BMI results.
Inspector #579 interviewed staff #111 who reported to the inspector that resident heights are not done annually.
Inspector #579 interviewed staff #112 who reported to inspector that they did not know if resident heights were done annually.
Inspector #579 reviewed the document; Hydration and Nutrition Procedure , Registered Nursing Staff Procedure and it is stated to "ensure the residents height and Body Mass Index is recorded on admission and annually thereafter". [s. 68. (2) (e) (ii)]

2. On September 24th, 2014 Inspector #542 reviewed the health care record for resident #6201. It was noted from the most recent MDS/RAI assessment that the resident's height was from a height documented in 2011 and the resident's weight was 42.4Kg for that month. The Quarterly Nutrition note from the RD for the next month revealed a weight of 48.8Kg, indicating a 6.4Kg weight gain in one month's time. Inspector #542 was unable to find a re-weigh or a current height. On September 25th, 2014 Inspector #542 interviewed the Nutrition Manager, (NM) who stated that the home does not conduct annual heights on the residents. The NM was also unaware if the home conducted re-weighs when there was such a discrepancy from one month to the other. Inspector #542 interviewed the Director of Care (DOC) in which they confirmed that the home does not have any policy or procedure with regards to re-weighs when there are discrepancies.
The licensee has failed to ensure that there is a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.O. Reg. 79/10, s. 69. [s. 68. (2) (e) (ii)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. Inspector #597 interviewed the President of the Residents' Council who reported that Resident Council does not participate in the review of snack/dining service or the menu cycle. The President of Residents' Council stated that there is a different committee for this.
The Nutrition Manager (NM) confirmed that on the minutes of the Menu Planning Committee for Sept 19, 2014, attendee names were not listed. The NM reported to the inspector that sometimes they do not record names but the committee is well attended.
The NM stated that the food committee meeting and resident council meetings are held on the same day (one in the morning and one in the afternoon) so there is a transfer of information. Inspector #597 was unable to verify that the Resident Council and Menu Planning Committee have common members.
The Nutrition Manager states that menu cycle, snack and meals times are communicated to resident council.
Review of menu cycle and meal and snack times are not reflected in the Resident Council meeting minutes that were provided by staff #101 for the dates of May 30, June 20, and September 19, 2014.
The NM provided a copy of Riverside Health Care - Approval of Long Term Care Menus Policy (no policy number, review dates not documented). The document states that the director of dietary services will provide the home's Resident Council with a copy of all menus and snack rotations for review. The home was unable to provide meeting minutes to support that this was done.
The licensee has failed to ensure that the home's menu cycle, (f) is reviewed by the Residents' Council for the home. O. Reg. 79/10, s. 71 (1). [s. 71. (1) (f)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Inspector #597 interviewed the President of the Resident's Council who reported that Resident Council does not participate in the review of snack/dining service or the menu cycle. The President of Resident's Council stated that there is a different committee for this.
Inspector #597 interviewed the Nutrition Manager (NM) who confirmed that on the minutes of the Menu Planning Committee for Sept 19, 2014, attendee names were not listed. The NM reported to the inspector that sometimes they do not record names but the committee is well attended. The NM stated that the food committee meeting and resident council meetings are held on the same day (one in the morning and one in the afternoon) so there is a transfer of information. Inspector #597 was unable to verify that the Resident Council and Menu Planning Committee have common members.
The NM stated that menu cycle, snack and meals times are communicated to resident council. The NM provided a copy of Riverside Health Care - Approval of Long Term Care Menus Policy (no policy number, review dates not documented)to Inspector #597. The document stated that the director of dietary services will provide the resident's council with a copy of all menus and snack rotations for review.
Inspector #597 noted that the review of the menu cycle and meal and snack times are not reflected in the Resident Council meeting minutes, that were provided by staff #101, for the dates of May 30, June 20, and Sept 19 2014.
The licensee has failed to ensure that that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1). [s. 73. (1) 2.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. On September 25th, 2014 the Administrator came and reported to Inspectors #579 and #597 that a Satisfaction Survey has not been completed or sent out by the home for approximately 2 years and that both Family and Residents' Council did not participate in the survey for advice, nor were any results shared with the councils.
The licensee failed to ensure that advice was obtained from the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. [s. 85. (3)]

2. On September 25, 2014 the Administrator came and reported to inspectors #579 and #597 that a Satisfaction Survey has not been completed or sent out by the home for approximately 2 years and that both Family and Residents' Council did not participate in the survey, nor were any results shared with the councils.
The licensee has failed to ensure that, (a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); (b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; (c) the documentation required by clauses (a) and (b) is made available to residents and their families; and (d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).
As evidenced by:
The President of the Resident Council was unable to confirm that the results of the survey were communicated to the council within the last 12 months.
The Administrator of the home, stated the Satisfaction Survey has not been completed since 2012. The home currently participates in Compliments, Concerns, Complaints program that aligns with the acute care site. The Satisfaction Survey was dropped as there was overlap.
The assistant appointed to the Resident Council - was unable to provide copies of Resident Council meeting minutes where the results of Satisfaction Survey were discussed. [s. 85. (4) (a)]

WN #13: 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. Inspector #579 interviewed residents #6129 and #6131 and inspector #577 interviewed resident #6157, all of whom were concerned about missing clothing and the probability of getting these articles back or not. The missing articles ranged from blouses, slippers and personal blankets.
On September 18th, 2014 inspector #579 interviewed staff #104 and #106 who stated that they find out about missing clothing or articles that residents have lost by phone calls from the nursing units or residents stopping them and asking about the item. Staff #104 said when they can't find the article right away by searching the residents room, with permission, they would come to the laundry room and write it on their "white board" and staff continue to watch out for the item.
Staff # 105 said there is no policy for missing articles but there is a procedure such as described that if it is a clothing item they have found, that is not labelled, they place it on a rack for a "couple of months" and if not claimed they donate the articles to the Diabetic Association. Staff #105 reported they get families and/or residents to come and check the racks if they are missing anything.
Staff #105 stated that if money or watches, hearing aids or other type articles are found in laundry these items are taken to the front office for the office to try to find out who is missing these items. Staff #105 and #106 stated they check pockets prior to loading the washers and if they can figure out who belongs to what they send it back to the resident. If staff #106 can not figure out who belongs to the article, or if it is money, they give them to staff #105. Despite a variety of efforts made by different staff there is no process per se for reporting and locating residents' lost clothing and personal items.
The licensee has failed to ensure that there a process to report and locate residents’ lost clothing and personal items. [s. 89. (1) (a) (iv)]

WN #14: 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. Over the course of the inspection, the Inspectors observed that in several of the resident's bathrooms toilet tank lids had duct tape over cracks to secure the lids to the tanks. Another resident's bathroom had a cracked toilet tank lid without any duct tape present. Some resident bathrooms were also noted to be either missing a vanity drawer or the drawer was found to be improperly secured.
The licensee has failed to ensure that procedures are developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks. [s. 90. (2) (d)]

Issued on this 16th day of December, 2014

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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) :	JANET MCNABB (579), BEVERLEY GELLERT (597), DEBBIE WARPULA (577), JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2014_339579_0016
Log No. / Registre no:	S-000351-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 15, 2014
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 :	Darryl Galusha

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)

Linked to Existing Order / Lien vers ordre existant: 2013_211106_0034, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Order / Ordre :

The licensee shall achieve compliance by ensuring that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Grounds / Motifs :

1. As a follow up to inspection #2013_211106_0034 whereas an order was issued to be complied with by May 31st, 2014, to ensure the registered dietitian who is a member of the staff is on site for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties and:
Previously; One Compliance Order (CO) under O. Reg 79/10, s. 74 (2) was issued in May 2013 during inspection # 2012_104196_0047 and One Voluntary Plan of Correction (VPC) under O. Reg. 79/10, s. 74 (2) was issued in July 2011.
On September 18th and then September 23rd, 2014 Inspectors #579 and #542 interviewed the Administrator and asked for the number of hours that the dietitian had been on site for the months of May, June, July and August 2014.
Inspector #579 also asked staff #111 to produce a list or verification of the same hours.
The Administrator was able to produce a payroll report that listed the number of hours per these months that the dietitian was on site which were:
May 2014 = 75 hours
June 2014 = 67.5
July 2014 = 67.5
August 2014 = 67.5
The Administrator had identified to inspector #542 that the Long Term Care Home also paid hours for the dietitian to be at the hospital.
Both the Administrator and staff #111 stated that they were "pretty sure" that the dietitian was "close" to meeting the required hours but recognized they have nothing to verify this is happening.
The home has the capability of having 164 residents, such that the required hours are 82 hours per month that the registered dietitian should be on site.
The licensee has failed to ensure that the Registered Dietitian (or dietitians) who is a member of staff of the home on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.
(579)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

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 15th day of December, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Janet McNabb

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