Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 10, 2015	2015_339617_0004	S-000481-13, S-000496-13	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

SHEILA CLARK (617), JENNIFER KOSS (616), LAUREN TENHUNEN (196)

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 13,14, 15, 16, 17, 2015

Inspector #617 attended the home to follow up on critical incident reports that related to falls prevention Logs #S-008311-14, #S-000496-13 and #S-000481-13; and reporting to the director, Log #S-000673-15.

During the course of the inspection, the inspector(s) spoke with Vice President, Director of Care (DOC), Acting Director of Care, Infection Control Practitioner (IFCP), Falls Program Lead, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The inspectors also conducted a daily tour of the home, observed resident care, and reviewed resident health care records and staff personnel files.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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 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 ensure that there was a written plan of care for each resident that set out, clear directions to staff and others who provide direct care to the resident.

The Critical Incident Report identified that a resident had a fall on October 2014 which resulted in transfer to hospital and injury. The health care records for the resident were reviewed for information regarding falls interventions. The care plan that was in place at the time of the resident's fall in October 2014, was reviewed with the focus of risk of injury with falls. The plan identified some interventions aimed at reducing the risk of injury from falls.

The resident care flow sheet included a category titled "Safety Device" Yes/No, and listed devices to be implemented by staff. There were no initials or checks to indicate any safety devices were being used that month. However, on the flow sheets for October 2014,"Y" was indicated sporadically. It was unclear what type of safety device was in use at the time of resident's fall as none of the listed devices were noted in the resident's plan of care. [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 there is a written plan of care for resident #004 that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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 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, is complied with.

Riverside Health Care Facilities Inc. policy entitled, "Falls Prevention Program" provided to Inspector #617 by a member of the registered staff, indicated that the post falls assessment and management procedure for the registered nurse to complete is the "Post Fall Screen for Resident/Environmental Factors", form #02/12, to assist in identifying possible contributing factors. The acting Director of Care reported that in 2013 the general incident form was rolled out online in Goldcare which is not a post fall assessment and that the expectation was for the staff to complete the post fall screen, form #02/12 on paper. The Director of Care reported that an audit of the use of the form was not done. Inspector #617 interviewed two registered nurses who reported that the post fall screen for resident and environment factors tool is to be completed post fall.

Inspector #617 interviewed a Registered Practical Nurse on duty who reported that the post fall screen for resident environment factors tool is no longer being used by the staff for assessing resident post fall and it is now online in Goldcare under incident report. Inspector #617 interviewed a Registered Nurse (RN) and an RPN who reported that the post fall assessment is documented in the general incident progress notes on Goldcare and that since 2013 registered staff have been instructed to chart the post fall assessment on Gold Care under general incident report. The Post Fall Screening tool, form #02/12, was not used when a resident falls contrary to the home's policy. [s. 8. (1) (a),s. 8. (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 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, and procedure specifically related to the falls prevention program is complied with and, to be implemented voluntarily.

WN #3: 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 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.

Critical Incident Report identified that a resident had a fall in August 2013, resulting in an injury. A review of "Post Falls Assessment and Management Registered Nurse Procedure" manual notes #8 identified registered staff to "complete the appropriate Post Fall Screening tool to assist in identifying possible contributing factors". Further, #9 of the manual instructs staff to "complete the appropriate fall risk assessment – LTC Scott Fall Risk (S1039)".

Inspector #616 interviewed the RAI Coordinator who confirmed that post-fall assessments are to be completed by paper copy filed in resident's health care record.

The assessments are not completed electronically using Goldcare.

Inspector #616 reviewed the archived health care record for the resident provided by the ward clerk, who reported that the "Scott Fall Risk Screening Tool" was completed once in January 2014 and once in April 2014.

One documented "Post-Fall Screen for Resident/Environmental Factors" (PFS) was completed by staff March 2014, correlating to the resident fall on the same date. A falls tracking form indicated that the resident had a fall in February, March, May and twice in June of 2014, a PFS was completed for those falls in 2014.

Inspectors #616 and #196 met with the lead for falls prevention to discuss procedures, assessments and management of residents who have fallen. The falls prevention lead identified that the Home is aware of noncompliance related to the application of the fall prevention program. The falls prevention lead reported that a gap analysis report was completed in February 2015, in collaboration with Registered Nurses' Association of Ontario (RNAO) Best Practice Consultant. It clearly identified that post-fall assessments have not been completed consistently by staff. The falls prevention lead confirmed the “Post Fall Screen for Resident/Environmental Factors” form is a requirement of Registered staff after every resident fall.

The RAI Coordinator confirmed to Inspector #616 that a post-fall assessment was not completed for the residentas required by the home's policy. [s. 49. (2)]

2. The licensee has failed to 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.

Critical Incident System report was submitted in December 2013, which indicated that a resident fell in November 2013. Inspector #617 reviewed the general incident progress notes obtained from Goldcare electronic records which indicated that the resident had 2 separate falls in November 2013. The first witnessed fall occurred as the resident self transferred from a chair and slid off the chair hitting their head. The second fall was unwitnessed where the resident was found sitting on the floor. The resident was sent to hospital and treated for their injuries. The resident returned to the home in December 2013.

Inspector #617 reviewed the resident falls tracking form which confirmed that the resident experienced a fall resulting in an injury. The "Post Fall Screen For Resident/Environmental Factors" was not found in the resident health care records. Inspector #617 interviewed an RPN who confirmed that documentation post fall for the resident was their responsibility and they did not complete the post fall screening tool. The RPN reported that since 2013, they had been instructed to chart post fall assessment as a general incident electronically in Goldcare. Inspector #617 interviewed an RN who reported that after a resident falls the incident is to be recorded on the tracking form, reported in the general incident progress notes on Goldcare and the fall risk and post fall screening tools are to be completed. A post fall assessment was not completed for the resident subsequent to their fall in November 2013. [s. 49. (2)]

3. The licensee has failed to 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.

A Critical Incident System report was submitted to the Director in October 2014, for a resident fall with injury which resulted in hospitalization.

A review of the resident's chart for information regarding the fall was completed. No record of the post-fall assessment was found for this fall. An interview was conducted by inspector #617 with the RAI Coordinator who reported that a post-fall assessment had not been completed for the resident after the fall in October 2014.

Inspector #616 interviewed the falls prevention program lead who reported post-fall assessments have not been completed consistently, they identified deficiencies in the home's falls program and confirmed that the post-fall screen for Resident/Environmental Factors is the tool used as a post-fall assessment to be completed after a resident has a fall. [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 to ensure that when a resident has fallen and where the condition or circumstances of the resident require, a post-fall assessment is conducted for every resident, using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4) an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. 6.

Public Health Ontario declared an Influenza A Outbreak at the home January 16, 2015, however, the home did not immediately notify the Director. A critical incident report was submitted to the Director on January 20, 2015. Intake notes by CIATT indicate no phone calls were received from the home to notify the Director of the outbreak prior to completion of Critical Incident Report.

Inspector #616 met with the Vice President of the home and teleconferenced with Director of Care. The Director of Care summarized their role during outbreak in collaboration with Public Health. The reporting process as explained by the Infection Control Practitioner to Inspector #616 is after outbreak is declared, the home's Director of Care/Administrator reports to the Ministry of Health via the Critical Incident System. The Vice President of the home confirmed that there was a delay in reporting the required Critical Incident Report to the Director. [s. 107. (1)]

Issued on this 11th day of August, 2015

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

Original report signed by the inspector.