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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 2, 2016	2016_339617_0021	016051-16	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)

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): May 30, 31, June 1, 2016.

This Critical Incident System Inspection is related to a critical incident submitted from the home to the Director.

During the course of the inspection, the inspector(s) spoke with Interim Director of Care (DOC), Physician, Food Service Manager (FSM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides (DAs), residents and family.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Nutrition and Hydration
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in their plan.

A Critical Incident (CI) Report regarding resident #001 was submitted to the Director. A review of the CI report indicated that during a meal resident #001 had a medical emergency.

A review of resident #001's health care records indicated they were dependent on staff for activities of daily living including set up help for eating. A review of the Registered Dietitian's quarterly assessment indicated that resident #001 was a moderate nutrition risk and required staff to monitor them while eating.

A review of resident #001's progress notes indicated that resident #001 had a total of three episodes of difficulty while eating. A specialist was referred to assess resident #001's eating difficulty. The specialist's assessment identified that resident #001 had difficulty eating and recommended resident #001 be offered a specially prepared diet. A review of resident #001's care plan, Dining Room Diet Sheet and Guide all provided direction to the staff that resident #001 required specially prepared diet for all meals.

The Inspector conducted a telephone interview with physician #107 who determined resident #001 had a chronic condition related to their disease.

The Inspector #617 interviewed PSW #104 who confirmed that they were working in the dining room when they became aware resident #001 was in distress, and called the registered staff to help.

Inspector interviewed DA #103 who confirmed they assisted resident #001 with set up with the meal, but did not provide the specially prepared diet at that time. DA #103 explained that previously to this episode, they provided the specially prepared diet to resident #001; however they were rushed and did not provide it. DA #103 clarified to the Inspector that they were aware resident #001 required a specially prepared diet. The FSM #102 informed DA #103 that resident #001 required a specially prepared diet; gave direction on how to prepare the special diet and reviewed with them the updated Dining Room Diet sheets.

The Inspector interviewed FSM #102, who confirmed that the Dietary Aides were responsible to prepare and provide special diets to residents who required it. FSM #102 further confirmed that they updated the Dining Room Diet sheets that gave direction to the staff on how to prepare the special diet for resident #001 and that DA #103 was informed of the diet change. FSM #102 expected the DA to provide to the residents special diets as directed on the Dining Room Diet Sheets.

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 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 :

The licensee has failed to ensure that the required policy for emergency planning dealing with medical emergencies, Regulation 79/10, s. 230 (4) 1. V, was complied with.

On June 1, 2016, during lunch service in the dining room, Inspector #617 observed a portable suction machine located beside the beverage counter with a garbage can and a pail with a mop blocking it.

A review of the home's policy titled "Emergency Plan - Code Blue" with no revision date indicated that a coordinated response will occur in the event of a Cardiac/Respiratory arrest for those residents wishing resuscitation. Upon discovering the emergency, staff were to bring the Red Emergency box, oxygen and suction to the scene and then after the event ensure that all emergency equipment was replaced/cleaned following the emergency such as the oxygen tank, suction machines, Bag Valve Mask (ambu) bag and all other used equipment.

Inspector interviewed RN #105 in the dining room on June 1, 2016, regarding the portable suction machine. RN #105 moved the garbage can and the pail with a mop aside to access the suction machine. Upon inspection of the suction machine, RN #105

confirmed to the Inspector that the suction machine was not readily available or operational in an emergency situation because its access was blocked and the tubing was used with debris in it. RN #105 explained that there was no clean tubing accessible on the cart to readily switch out.

The Inspector interviewed RPN #106, who reported that registered staff were responsible for checking on a weekly basis that the suction machine located in the dining room was readily operational and record the same in the Nursing Journal Checklist.

The Inspector reviewed the Nursing Journal Checklists for the month of May 2016, and found that on three days, there were missing check marks. During an interview with RPN #106, they confirmed to the Inspector that the Nursing Journal checklist for the suction machine located in the dining room was not checked for the month of May because documentation was missing for the days it was to be checked.

The Inspector interviewed RN #105 regarding the suction machine located in the clean utility room beside the nursing station. The RN #105 confirmed to the Inspector that the suction machine was not readily operational in an emergency situation because the tubing was outdated, needed to be replaced and was not readily available.

The Inspector interviewed RN #105, who explained that the registered staff were to check every week that the suction machine located in the clean utility room was readily operational and record the same in the Nursing Journal Checklist.

The Inspector reviewed the Nursing Journal Checklists for the month of May 2016, and found that on three days the suction machine was to be checked, and there were missing check marks. During an interview with RN #105, they confirmed to the Inspector that the suction machine in the utility room was not checked for the month of May because documentation was missing for the days it was to be checked, in the Nursing Journal Checklist.

Inspector interviewed the interim DOC who reported that the registered staff were responsible to check that all suction machines were readily operational for an emergency situation in response to a resident requiring suctioning and document the same on the Nursing Journal Checklists. The interim DOC confirmed to the Inspector that both suction machines should have been checked, operational and available to respond in an emergency situation but were not at the time of the inspection.

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 in which the required policy for emergency planning dealing with medical emergencies, Regulation 79/10, s. 230 (4) 1. v, is complied with and updated to ensure all suction machines are available and readily operational for a medical emergency, to be implemented voluntarily.

Issued on this 11th day of August, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2016_339617_0021
Log No. / Registre no:	016051-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 2, 2016
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 :	Emily Bosma

To RIVERSIDE HEALTH CARE FACILITIES, INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall,
a) Establish and implement a monitoring system that ensures special dietary requirements are offered daily to those residents who require them at each meal by staff responsible to provide them.
b) Audit and provide corrective actions to ensure quality of food service provision is obtained.
c) Maintain records of the results of the audits and corrective actions.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in their plan.

A Critical Incident (CI) Report regarding resident #001 was submitted to the Director. A review of the CI report indicated that during a meal resident #001 had a medical emergency.

A review of resident #001's health care records indicated they were dependent on staff for activities of daily living including set up help for eating. A review of the Registered Dietitian's quarterly assessment indicated that resident #001 was a moderate nutrition risk and required staff to monitor them while eating.

A review of resident #001's progress notes indicated that resident #001 had a total of three episodes of difficulty while eating. A specialist was referred to assess resident #001's eating difficulty. The specialist's assessment identified that resident #001 had difficulty eating and recommended resident #001 be offered a specially prepared diet. A review of resident #001's care plan, Dining Room Diet Sheet and Guide all provided direction to the staff that resident #001

required specially prepared diet for all meals.

The Inspector conducted a telephone interview with physician #107 who determined resident #001 had a chronic condition related to their disease.

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The decision to issue an order was based on the actual harm of resident #001. Although the scope was isolated, there was a history of previous noncompliance specific to LTCHA 2007, S.O. 2007, c. 8, s. 6, identified during the following inspections:
-A written notice (WN) was issued in Complaint Inspection #2014_380593_0007, served to the home on August 14, 2014,
-A voluntary plan of correction (VPC) was issued in Resident Quality Inspection #2014_339579_0016 served to the home on September 16, 2014,
-A voluntary plan of correction (VPC) was issued in Critical Incident System Inspection #2015_339617_0004 served to the home on April 14, 2015,
-A voluntary plan of correction (VPC) was issued in Resident Quality Inspection #2016_246196_0001 served to the home on January 4, 2016. (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 2nd day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sheila Clark

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