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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 3, 2016	2016_320612_0019	002923-14, 004145-14, 005866-15, 017852-15, 004184-16, 005047-16, 011576-16, 012346-16, 013672-16, 013850-16, 014299-16	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

SARAH CHARETTE (612), SYLVIE LAVICTOIRE (603)

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): June 20-23, 2016.

This Critical Incident (CI) Inspection is related to six CIs related to resident abuse and five CIs related to residents who fell.

A Follow Up Inspection #2016_320612_0017 and Complaint Inspection #2016_320612_0018 were conducted concurrently to this inspection. The following findings of non-compliance from this inspection were issued in the Complaint Inspection #2016_320612_0018 report: LTCHA, 2007 s. 19. (1)., s. 20. (1)., s. 23. (1). (a)., s. 23. (2)., and s. 24. (1).

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Nutrition and Food Services Supervisor, Resident Assessment Instrument (RAI) Coordinator, Administrative Assistant, Activation Coordinator, Education Coordinator, Housekeeper, Payroll worker, residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions, reviewed residents' health care records, staff training records, policies, procedures, programs, and staff personnel files.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each organized program required under sections eight to sixteen of the Act and section 48 of the regulation, there was a written description of the program that included it's goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Inspector #612 reviewed five Critical Incident (CI) Reports related to five resident falls. During an interview with Unit Coordinator #103, they stated that after a resident fell, they would complete an incident report specifically related to falls, a falls tracking form and a post fall screen for resident/environmental factors. They also stated that they would complete a Scott Fall Risk Screening Tool to assess the resident's fall risk on admission, quarterly and if there was a change in the resident's condition. The Unit Coordinator #103 stated that they did not formally meet anymore to discuss a resident's fall; however,

they would talk with the PSW's, the RPN's and the Adjuntive (Physiotherapist) as needed to determine if new interventions needed to be trialed or implemented. There was no formal process for referral to specialized resources. The Unit Coordinator #103 reported that there was no written description of the procedure they followed once a resident fell.

The Inspector requested the home's Falls Prevention and Management Program and was provided three pages by the Administrator. They stated that the home had amalgamated with two other sites and they had adopted the same policies.

The Inspector reviewed the home's policy titled, "Falls Prevention Program Policy," last reviewed September 29, 2015, which outlined the policy, the purpose and the responsibility of staff. The "Falls Prevention Program Nursing Procedure," last reviewed September 29, 2015 provided instruction to the registered nursing staff for the falls prevention program. It stated the following:
- Assess fall risk upon admission using the appropriate assessment tool.
- Reassess residents for change in falls risk when there has been a significant change in condition, when a long term care resident had been admitted to an acute care facility and returns to the facility, quarterly for long term care residents, and when there has been a fall.
- Collaborate with the interdisciplinary team in the prevention of falls.
- Appropriately manage residents who experience a fall.

The policy did not identify the assessment tool to determine the resident's falls risk, a procedure for referral to specialized resources and the steps to appropriately manage residents who experienced a fall.

Ontario Regulation 79/10 r. 30. (1). 1. states that there must be a written description of the program that includes it relevant policies, procedures and protocols, including protocols for the referral of residents to specialized resources where required.

The Inspector interviewed the DOC who confirmed that the home's written program did not provide the procedures that staff were implementing within the home related to the Falls Prevention and Management Program. [s. 30. (1) 1.]

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 description of the home's Falls Prevention and Management Program, that includes the relevant policies, procedures and protocols and provides methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the names of all residents involved in the incident.

Inspector #612 reviewed a CI report which described an incident between a family member of a resident and a staff member. The CI report stated that there were residents present during the incident and they had felt threatened and reported the incident to RPN #115 the next day. The report did not provide the names of the residents that felt threatened.

The Inspector interviewed the DOC who stated that the residents were not directly involved therefore they did not name the residents in the report.

The Inspector interviewed RPN #115. They stated that they were approached by resident #010 the day after the incident and the resident reported that they had felt scared by the events that took place the day prior. RPN #115 stated that they had been approached by other residents as well to report the incident but could not recall their names. RPN #115 reported that resident #010 was able to provide a detailed description of the incident as the resident was present in the dining room when it occurred.

The Inspector interviewed the Nutrition and Food Services Supervisor #102 who stated that they investigated the incident and confirmed that as part of their investigation they interviewed resident #010, as they were present in the dining room.

The Inspector interviewed resident #010 who was able to confirm that they were present in the dining room when the incident occurred. [s. 104. (1) 2.]

Issued on this 3rd day of October, 2016

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

Original report signed by the inspector.