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

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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 6, 2016	2016_264609_0019	019371-16, 019758-16, 020739-16, 023000-16	Complaint

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

CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 19-22, 2016.

This inspection was conducted as a result of four Complaints that were submitted to the Director which alleged multiple incidents of resident to resident physical and sexual abuse, disrepair of the home, as well as a lack of supplies in the home.

A Critical Incident (CIS) inspection was conducted concurrently with this inspection. Non-compliances found during the CIS inspection were issued in this Complaint report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Activation Manager, Maintenance Manager, Nutrition Manager, Physiotherapist, Ward Clerk, Supply Purchaser, Medical Director, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance Workers, Housekeepers, Ward Clerk, Behavioural Supports Ontario (BSO) Workers, residents and family of residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed numerous licensee policies, procedures, and programs, complaint logs, internal investigations, relevant health care records, staffing schedules, human resource files, and training logs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and in caring for their personal needs was fully respected and promoted.

A Complaint was submitted to the Director which indicated that resident #003 had no privacy curtains or window coverings in their room.

On a specified day the Inspector observed resident #003 clearly visible in their room from the home's court yard. Further observations within the resident's room found no window coverings of any kind.

During an interview with the home's Maintenance Manager they indicated that they were aware of the current lack of privacy in the resident's room and that the lack of privacy had been going on for months. The Maintenance Manager stated no when asked if any new strategies or interventions had been implemented to address resident #003's lack of privacy.

During an interview with the Administrator they stated yes when asked if it was the expectation of the home that all residents were afforded privacy in treatment and in care. The Administrator stated no when asked if resident #003's right to privacy was fully respected and promoted. [s. 3. (1) 8.]

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 resident's right to be afforded privacy in treatment and in caring for their personal needs is fully respected and promoted, especially those of resident #003, to be implemented voluntarily.

WN #2: 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. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A Complaint was submitted to the Director which indicated that the ceiling in the home's main hall was bubbling out, cracking and posed a risk to everyone in the home when the pieces fell to the floor.

Inspector #609 observed on two specified days, the ceiling in the home's west main hall and verified the plaster on the ceiling above tables and chairs where residents and family members were observed to be socializing, was cracking apart and noted plaster had fallen on the window ledges.

In an interview with Housekeeper #102 they said that the falling pieces of the ceiling had been an ongoing concern for three years.

A review of the home's "Outstanding Hazards Tracking" form found that since at least November 8, 2014, staff had identified the ceiling as a concern and a risk to others related to ceiling pieces falling onto people.

In an interview with the Maintenance Manager they said that they were aware that the ceiling was in disrepair and verified that despite the risk to others the home had done nothing to fix the ceiling in over 20 months. [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 are maintained in a safe condition and in a good state of repair, especially the ceiling in the home's main hall, to be implemented voluntarily.

WN #3: 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 in respect of each of the organized programs required under sections eight to 16 of the Act was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A complaint was submitted to the Director which indicated that there have been gaps in activation staff coverage in the home's secured unit when an activation staff member went on parental leave as well as outlined "serious maintenance issues".

a) A review of the activation staff coverage in the home's secured unit for the 10 days since Activation Worker #109 went on parental leave indicated five or 50 per cent of the time no activation staff provided any services within the home's secured unit.

During an interview with the Activation Manager they were unable to provide a policy or procedure related to the home's organized program of recreational and social services as it was "too vague". The Activation Manager verified the five days cited whereby no activation services were provided to residents on the secured unit. They indicated that there was currently no annual evaluation of the organized program of recreational and social services in the home.

b) During an interview with the Maintenance Manager a review was conducted of the home's policy titled "Maintenance Responsibilities" last reviewed January 2004 which found no mention that the program or policy was evaluated annually or at all.

In the same interview with the Maintenance Manager they said that the organized program of maintenance as well as the housekeeping and laundry services which the Maintenance Manager coordinated were also currently not evaluated.

A review of the Regulation was conducted with the Administrator who said yes when asked if it was the expectation of the home that the maintenance and activation services programs as well as all other required programs were evaluated annually and that this did not occur. [s. 30. (1) 3.]

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 in respect of each of the organized programs required under sections eight to 16 of the Act is evaluated and updated at least annually in accordance with evidence-based practices and, if there is none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

A complaint was submitted to the Inspector indicating that the home had been without toothpaste to brush resident's teeth for over one month.

During an interview with RN #108 they said that the home has been without toothpaste for over one month and that personal support staff have been using mouthwash in lieu of toothpaste to perform oral care.

During an interview with the home's Ward Clerk they said that toothpaste had been back ordered for approximately six weeks and was told "it would cost too much" to purchase toothpaste outside of the home's contracted provider.

During an interview with the home's Supply Purchaser they said they were aware that the home was without toothpaste for six weeks and verified they told the Ward Clerk that it was "cost prohibitive" to purchase toothpaste outside of the contracted provider. [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #5: 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,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the heating, ventilation and air conditioning systems (HVAC) were inspected at least every six months by a certified individual, and that documentation was kept of the inspection.

A complaint was submitted to the Director on June 27, 2016, which outlined "serious maintenance issues".

On a specified day the Inspector observed a fuzzy mold-like material protruding from the west side medication room air vent.

During an interview with the Maintenance Manager they were unable to produce documentation that a certified individual had inspected the home's HVAC system.

During interviews with Maintenance Workers #103 and #104 they verified neither of the three Maintenance Workers in the home nor the Maintenance Manager were certified to inspect the home's HVAC system but were inspecting the HVAC system for years as if they were certified. [s. 90. (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 heating, ventilation and air conditioning systems are inspected at least every six months by a certified individual, and that documentation is kept of the inspection, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and were not neglected by the licensee or staff.

Two Complaints were submitted to the Director which alleged resident #001 physically abused multiple residents since admission.

a) The Inspector reviewed the health care records for resident #001 for a specified time frame found 11 incidents whereby that the resident had physically assaulted and subsequently injured other residents in the home.

A review of the home's policy titled "Abuse and Neglect Zero Tolerance" no revision date indicated that physical force by a resident that caused physical injury to another resident constituted physical abuse and that the home's administration was to immediately initiate a report of the abuse to the Ministry of Health and Long Term Care.

A review of resident #001's health care records was conducted with the Administrator and RN #101 who both indicated that it was the expectation of the home that abuse of a resident by anyone should have been immediately reported to the Director and that in the case of the 11 identified abuse incidents involving resident #001 staff did not comply with the home's abuse policy.

b) A review of the home's annual mandatory retraining of staff in responsive behaviours for the 2015 year found that 90 of 107 staff or 84 per cent did not complete the retraining in the management of responsive behaviours.

During interviews Physiotherapist #115, as well as PSWs #110 and #111 all stated that had not received any training in the home's Responsive Behaviours program in the 2015 year.

A review of the home's policy titled "Responsive Behaviours" with no revision date made no mention that staff were to be retrained annually on the home's Responsive Behaviour program or policy.

During an interview with the Administrator they stated yes when asked if it was the expectation of the home that all staff were retrained annually in the home's Responsive Behaviours program and verified that this did not occur with 84 per cent of the home's staff for the 2015 year.

c) During interviews with Behavioural Supports Ontario (BSO) #105 and #106 they both stated that they have read only access to the home's online documentation system (Goldcare) and as a result placed their notes, observations and recommendations to staff for residents demonstrating responsive behaviours in a BSO binder located at the nursing stations.

During interviews PSW #112, #113, and #114 all stated that when a resident demonstrated responsive behaviours, they would review the printed copy of the resident's plan of care located in a binder at the nursing station. None of the PSWs identified the home's BSO binder as an additional component of the resident's plan of care in the management of responsive behaviours.

A review of the BSO recommendations for resident #001 directed staff to ensure a specific interventions was in place to manage resident #001's responsive behaviours.

A review of the current plan of care for resident #001 found no mention that staff were to have ensured that the specific intervention was in place.

During the same interview with BSO #105 and #106 they both stated that it has been a challenge for the special care unit staff to incorporate their recommendations in the care of residents demonstrating responsive behaviours.

d) A review of the current plan of care for resident #001 indicated that staff were to have ensured two specific interventions were in place to manage resident #001's responsive behaviours.

On a specified day the Inspector observed resident #001 in their room where neither of the two specific interventions were in place. The Inspector also observed a different intervention applied to the resident's door that was not in their plan of care.

During an interview with PSW #100 they verified that though they were unsure for how long the two specific interventions were not being used or when a different intervention was initiated to manage the resident's responsive behaviours.

During an interview RN #101 stated yes when asked if it was the expectation of the home that when a resident's needs change that the plan of care was reviewed and revised and that this did not occur related to the change in care to manage resident #001's responsive behaviours. [s. 19. (1)]

2. Two Complaints and one CIS report were submitted to the Director alleging resident #002 physically and sexually abused multiple female residents in the home.

a) The Inspector reviewed resident #002's health care records for a specified time frame and found six incidents of physically or sexually abusive responsive behaviours causing injury directed towards female residents in the home.

A review of the home's policy titled "Abuse and Neglect Zero Tolerance" with no revision date indicated that any witnessed, unwitnessed or alleged abuse was to be reported to the home's administration immediately.

A review of resident #002's health care records was conducted with the Administrator and RN #101 who both indicated that it was the expectation of the home that staff follow the home's zero tolerance of abuse of residents policy and immediately report the information to the administration and that in the case of the six identified abuse incidents involving resident #002 this did not occur.

b) The Inspector reviewed the health care records for resident #002 for a specified time frame found 23 incidents of sexually inappropriate behaviours.

A review of the current plan of care for resident #002 found that sexual responsive behaviours was recognized with corresponding interventions for their management three months after the resident's sexually responsive behaviours and incidents were identified.

During interviews with the Administrator and RN #101 they both stated yes when asked if it was the expectation of the home that the plan of care would identify any responsive behaviours a resident demonstrated and that resident #002's plan of care should have identified the resident's sexually responsive behaviours when they manifested.

c) A review of the health care records for resident #002 found that for a specified time frame resident #002 demonstrated sexually responsive behaviours towards resident #005 in at least five separate incidents.

A review of the health care records for resident #002 and #005 was conducted with BSO #105 and #106 who both verified that resident #005 was a trigger and at risk from resident #002's sexually responsive behaviours and that this should have been identified in both residents' plans of care.

A review of the home's policy titled "Responsive Behaviours" no revision date indicated that staff were to "identify the causes and triggers for the behaviour" and to "develop a comprehensive plan of care to ensure resident well-being and quality of life".

A review of the current plan of care for resident #002 found no mention that resident #005 was a trigger for sexually responsive behaviours.

A review of the current plan of care for resident #005 found no mention that they were at risk from or interventions to maintain the resident's safety from the sexually responsive behaviours of resident #002.

During interviews with the Administrator and RN #101 they both stated yes when asked if it was the expectation of the home that triggers for responsive behaviours were to be identified in the plans of care of residents demonstrating responsive behaviours and that this did not occur for resident #002 and #005.

There is currently an outstanding compliance order from Complaint Inspection (#2016_320612_0018) related to s.19.(1). [s. 19. (1)]

Issued on this 7th day of October, 2016

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

Original report signed by the inspector.