Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
March 8-9,15, 2011	2011_122_8608_07Mar143021	Complaint S-000626 S-000667 S-000678 (IL-15420)

Licensee/Titulaire
Riverside Heath Care Facilities Inc.
110 Victoria Avenue
Fort Frances, ON P9A 2B7
Fax: 807-274-2898

Long-Term Care Home/Foyer de soins de longue durée
Rainycrest
Fax: 807-274-7368

Name of Inspector(s)/Nom de l'inspecteur(s)
Rose-Marie Farwell, 122

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct 3 complaint inspections.

During the course of the inspection, the inspector spoke with: the Administrator, the Unit Care Coordinator, the Float RN, 2 RPN's 2 PSW's, 5 residents, 3 family/friends.

During the course of the inspection, the inspector: reviewed resident health care records, observed provision of care and services to the residents of the home and the home's environment.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home
Sufficient Staffing
Reporting & Complaints

6 Findings of Non-Compliance were found during this inspection. The following action was taken:

6 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, O. Reg. 79/10, s. 129 (1) (a) (ii)

Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or medication cart,

(ii) that is secure and locked,

Findings:

1. On March 8, 2011, a medication cart was observed unattended and unlocked on the East Wing (Atikokan Bay). The RPN was observed in a resident's room, 5 rooms away from where the cart had been left.

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WN #2: The Licensee has failed to comply with LTCHA 2007, S.O., c. 8, s. 3 (1) 5

Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: Every resident has the right to live in a safe and clean environment.

Findings:

1. The resident lift located outside of room W4 was observed to have a build up of dust and dirt on the lower frame and was in need of cleaning.
2. A juice spill equivalent to approximately 8 oz. and scattered over an area approximately 10-12 inches in diameter was observed spilled on the floor beside a table located across from room W35. Two residents were seated at the table and a staff member was observed walking around the spill. No attempt to clean the spill was observed, presenting a slip/fall hazard to residents, staff and visitors.
3. The recliner located in the hallway across from room W71 was observed to be soiled with numerous stains of unknown origin, worn and torn.
4. The scale located outside of room E67 was observed with a build up of dust and dirt and in need of cleaning.

Inspector ID #:	122

WN #3: The Licensee has failed to comply with LTCHA 2007, S.O., c. 8, s. 3 (1) 1
Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Findings:

1. March 8, 2011 @ 1515 hrs. East Wing. A resident was sitting in their wheelchair in the common area of the East Wing. The resident requested that the Inspector move her to the window. The Inspector stated that the staff member in the room would assist them. The staff member was heating an item in the microwave while directing their attention to the TV and ignored the Inspector's comment. The resident directed their attention to the staff member and made 2 requests to be moved to the window. The resident's requests were ignored. Upon the resident's 3rd request, the staff member responded "No, you're okay" and left the common area without providing assistance to the resident.

2. March 8, 2011 West Wing 1500 hrs, a resident was observed seated in a broda chair in the common area of the West Wing Special Care Unit. The resident's socks were on the floor beside their chair, the resident's sweater was also observed on the floor. The resident's clothing was soiled with several food stains. The resident was observed sitting in front of the TV with the volume turned off. The resident was not included in the Mardi Gras Festivities which were in progress outside the main dining room of the home. The resident was seated approximately 15 feet away from where the festivities were taking place.

Inspector ID #:	122

WN #4 : The Licensee has failed to comply with LTCHA 2007, S.O. c. 8, s. 151 (1) (a)
Every person is guilty of an offense who,

(a) hinders, obstructs or interferes with an inspector conducting an inspection, or otherwise impedes an inspector in carrying out his or her duties.

Findings:

1. In an attempt to identify the resident's care giver described in WN # 3, the Inspector followed the staff member from the common area to the hallway and twice asked them to identify their classification. The staff member ignored the Inspector's question. Upon the Inspector's 3rd request the staff member asked the Inspector's identity, which was provided. The staff member still did not identify their classification but instead questioned the Inspector's specialty, then questioning if the Inspector's purpose was to inspect "the building". The staff member only identified their classification and then their name after they learned the Inspector's specialty was nursing.

Inspector ID #:	122

WN # 5 The Licensee has failed to comply with LTCHA 2007, S.O. c. 8, s. 22 (1)

Every licensee of a long-term care home who received a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

Findings:

1. A written complaint was received by the home on September 23, 2010 by electronic mail. The e-mail was sent to the Unit Care Coordinator; the Director of Care and Administrator were copied. This complaint was not forwarded to the ministry.

Inspector ID #:	122

WN # 6 The Licensee has failed to comply with LTCHA 2007, O. Reg. 79/10, s. 101 (2)

The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, timeframes for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which a response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant

Findings:

1. The licensee failed to ensure that a documented record of an email which identified "complaint" in the subject heading was kept; and that the documented record was consistent, with the requirements outlined in O. Reg. 79/10, s. 101 (2) of the Act. The Administrator denied knowledge or receipt of a "written complaint" from the complainant.

Inspector ID #:	122

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report: March 28, 2011**