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
Apr 3, 2017	2017_395613_0002	033826-16, 034034-16	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

LISA MOORE (613)

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): January 9 - 13, 2017

The following intakes were completed during this inspection:
Two complaints submitted to the Director related to concerns with the provisions of care.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Administrative Assistant (AA), Pscyhogeriatric Lead, and Outreach PSW from the Canadian Mental Health Association - Fort Frances Branch.

A concurrent Critical Incident Inspection #2017_395613_0001 was also completed during this inspection.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of their choice, including tub bath, showers, and full sponge baths,

and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was received by the Director in December 2016, regarding resident #009 not receiving their scheduled baths for two weeks between November and December 2016.

Inspector #613 reviewed the home's forms titled, "Bath Schedule Days," and "Bath Schedule Evenings" and determined that resident #009 had been scheduled for a day bath on a specific day and an evening bath on a specific day. The care plan in place at the time of the complaint, identified resident #009 required the assistance of a staff member, but was capable of limited independent bathing care. It was identified on the care plan that resident #009 should have had showers only. The care plan did not identify if resident had resisted or refused care/showers.

The Inspector reviewed the PSW Flow Sheets from November 2016 to December 2016. The PSW Flow Sheets identified that two tub baths had been documented as being provided on two scheduled dates, during that time period. The PSW Flow Sheets did not identify documentation, under the bathing heading, for five scheduled dates in November 2016. There was no other documentation to identify that baths had been provided on other unscheduled bath dates. Only two out of seven baths had been documented as being provided for that time period.

A review of the electronic progress notes on Gold Care did not identify any documentation regarding why resident #009's scheduled showers had not been provided on the above mentioned dates or if a bed bath had been provided by the staff.

During interviews with PSW #105 and RPN #106, both stated that Personal Support Workers (PSWs) were expected to document, as per the legend on the PSW Flow Sheets, when a bath had been provided to a resident and if a bath was not provided to a resident as scheduled, PSWs were to write refused on the PSW Flow Sheets and then report to the RPN on duty, who would document in the residents progress notes. RPN #106 stated a resident should not go a long period of time without a bath. PSW #105 stated if a bath was not documented for an extended period of time, then it was not provided.

A review of the home's departmental procedure titled, "Bathing" with no revision date, identified each resident would be bathed twice per week using the daily schedule. The residents’ personal preferences and needs would be taken into account when scheduling

the baths.

On January 11, 2017, the Inspector interviewed the Director of Care (DOC), who confirmed there was no documentation on the PSW Flow Sheets for resident #009's scheduled bath dates. The DOC stated it was their expectation that there should have been documentation on the PSW Flow Sheets and the progress notes on Gold Care to identify why a resident did not receive their scheduled bath. The DOC further stated that if it was not documented, then the bath had not been provided. [s. 33. (1)]

Issued on this 7th day of April, 2017

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

Original report signed by the inspector.