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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Apr 13, 2017;	2016_463616_0026 (A3)	028562-16	Resident Quality Inspection

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

JENNIFER KOSS (616) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The grounds of CO #004 have been amended to identify three residents (#001, #006, #007) who were unintentionally omitted from Inspection report #2016_463616_0026 (A2).

Issued on this 13 day of April 2017 (A3)

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

Original report signed by the inspector.

Ontario

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

JENNIFER KOSS (616) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 14-18, 21-25, 2016

Additional intakes completed during this inspection included:

A follow up of past due compliance order #001 identified in Inspection #2016_339617_0021, Long-Term Care Homes Act (LTCHA) s. 6(7); a follow up of past due compliance order #002 identified in Inspection # 2016_320612_0018, LTCHA s. 20; and a follow up of past due compliance order #001 identified in Inspection #2016_320612_0018, LTCHA, s. 19 (1).

A Complaint intake related to complaints of alleged resident neglect and pain management.

Three Critical Incident intakes related to critical incident system (CIS) reports that the Home submitted regarding resident to resident abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator (AD), Acting Director of Care (Acting DOC), Manager-Food and Nutrition, Infection Control Practitioner (ICP), Resident Assessment Instrument

Assistant Coordinator (RAI Coordinator), Administrative Assistant (AA), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides (DAs), Activity Aides, family members/care givers, and residents.

During the course of the inspection, the Inspectors directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, various home policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

10 WN(s)
1 VPC(s)
5 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 20. (2)	CO #002	2016_320612_0018	577

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. 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 :

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

Inspector #617 was following up on outstanding Compliance Order #001 issued during Inspection #2016_339617_0021 with a compliance date of August 31,

2016. The licensee was ordered to:

a) Establish and implement a monitoring system that ensures special dietary requirements including thickened fluids 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.

While the home completed items "b" and "c" of the order, regarding item "a", Inspector #617 found during this inspection that resident #006 had special dietary requirements that were not offered at meals by the staff responsible to provide them in the dining room.

A review by Inspector #616 of the Registered Dietitian's (RD) assessment indicated that resident #006's nutritional risk level had been determined. Interventions to mitigate this risk were included in the plan of care.

On November 22, 2016, Inspector #616 reviewed the Dining Room Diet Sheet which indicated that resident #006 was to have specific nutrition interventions at each meal.

On a day in November, 2016, the Inspector observed resident #006 in the dining room during a meal service. Personal Support Worker (PSW) #106 was observed by the Inspector as they requested the resident's plate at the servery and then offered the prepared plate to resident #006. During this observation, one of the specific nutrition interventions was not added to the meal by the Dietary Aide (DA) at the servery nor by the PSW at meal delivery.

During an interview with PSW #106 during this meal service, they stated to the Inspector that resident #006 was not ordered any nutritional interventions with meals. They stated that if so, the information would be on the diet sheet. Inspector #616 reviewed the resident's nutritional interventions ordered on the diet sheet with PSW #106. They confirmed to Inspector #616 that this was the current diet sheet, it indicated the nutritional interventions and that they should have provided the nutrition interventions to resident #006 but had not.

On a day in November, 2016, Inspector #616 observed resident #006 during another meal service in the dining room. The resident did not have their specific nutrition interventions at their place setting on the table, and through the observation this resident was not provided this intervention by staff. PSW #107 was observed as they served the meal to resident #006 after preparation by DA #108. No specific nutrition interventions were observed to have been provided by either DA #108 or PSW #107.

During an interview with PSW #107 during the meal service, they confirmed to Inspector #616 that resident #006 had not received any nutritional interventions during the meal. PSW #107 also stated to the Inspector that the diet sheet in the dining room provided them with specific information related to diet orders. Together, the PSW and the Inspector reviewed the diet sheet for resident #006. The PSW confirmed this resident had not received either of the nutritional interventions for months.

Inspector #616 interviewed DA #108 after the meal service. They explained to the Inspector that the DAs were responsible to provide this specific nutrition intervention to resident #006 only at the PSW's request. DA #108 confirmed to the Inspector that resident #006 had not received their nutrition intervention on this day. The DA stated that one specific nutrition intervention had not been provided to resident #006 for months, that the other nutrition intervention had not been available in the dining room for a length of time and had not been provided to resident #006.

A review of the home's policy titled "Nutrition and Hydration Program Policy", #P-VI-3, revised on June 17, 2013, indicated that the Registered Staff were to ensure that special dietary requirements were administered as ordered by the Physician or Dietitian; and the Direct Care Staff were to record or report the resident's diet and fluid intake as directed.

On November 23, 2016, in an interview with the Manager, Food and Nutrition and the Acting Director of Care (DOC), they explained to Inspector #617 that special dietary requirements ordered by the RD for residents were to be either added or offered to the resident at each meal by the PSW and DAs in the dining room. The staff were to follow the diet sheet located in the dining room and record the volume of consumed food on the residents' nutrition intake charts. The Manager, Food and Nutrition, was unable to provide evidence that resident #006 was provided with their special dietary requirements and confirmed to the Inspector that the supply of

one of the interventions had been low, would no longer be available, and had not informed the RD or the Physician to provide a substitute. [s. 6. (7)]
(617)

2. On a day in November, 2016, Inspector #196 observed the dining service on a specific unit.

The diet sheet for the unit was reviewed and identified that residents #012 and #008 were to receive specific nutrition interventions with their meals.

An interview was conducted with DA #100 and they reported that the DAs added the specific nutrition interventions to the residents' plated food. They confirmed to the Inspector that neither resident #012 nor resident #008 had received the nutrition interventions as identified on the diet sheet as they had forgotten to do so.

On November 17, 2016, an interview was conducted with the Manager, Food and Nutrition. They reported that the DAs were to provide the specific nutrition interventions to those residents identified on the diet sheet.

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 LTCHA, 2007, 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.

A Critical Incident System (CIS) report was received by the Director alleging sexual abuse by resident #028 towards resident #018. The report indicated that 22 days before the report was submitted to the Director, resident #018 was observed to be visibly upset by the incident.

A review of resident #028's care plan by Inspector #577 specific to inappropriate responsive behaviours, effective at the time of the incident, indicated a history of specific behaviours and identified certain interventions by staff.

The home's policy in place at the time of the incident, titled, "Abuse and Neglect Zero Tolerance Policy", with no previous revision date, was reviewed by Inspector #577 that indicated the following:

-Persons having reasonable grounds to suspect abuse or neglect had occurred had an obligation to report it to administration immediately;

-All reported incidents shall be investigated; and

-Registered staff were to notify the Substitute Decision Maker (SDM) of an incident immediately if injury occurred, or within 12 hours for all other situations.

Inspector #577 conducted an interview with the current Acting DOC on November 22, 2016, who reported that this incident had not been immediately reported to Administration or investigated. This Acting DOC also stated that it had not been reported to the Director until 22 days later, and that resident #018's SDM had not been notified.

During an interview on November 24, 2016, with the AD and RN #110, who had previously been in the Acting DOC role at the time of the incident, reported that RPN #120 had witnessed the incident, had documented a progress note, but had not reported it to anyone. They further reported that RN #122 had read the progress note the following day and updated the resident's care plan with interventions but did not immediately report it to Administration or the Director.

They further confirmed that through a record review the incident was discovered by RN #110 and Inspector #609 during a previous inspection in which a CIS report was initiated.

According to the LTCHA, 2007, s. 97 (1) (b), every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. The incident of resident to resident abuse involving resident #028 toward resident #018 was not reported to resident #018's SDM.

According to the LTCHA, 2007, s. 104 (1) (2) (i), in making a report to the Director, 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: a description of the individuals involved in the incident, including, names of all residents involved in the incident. The report of resident to resident abuse involving resident #028 toward resident #018, did not identify resident #018.

The non-compliance identified in this finding had occurred prior to the compliance due date of November 3, 2016. [s. 19. (1)] (577)

2. Inspector #577 was following up on outstanding Compliance Order #001 issued during Inspection #2016_320612_0018 with a compliance date of November 3, 2016. The licensee was ordered to:

a) Ensure that all residents are protected from abuse by anyone and not neglected by the licensee or staff.

b) Review, revise and update resident #016's care plan to ensure that the interventions were effective to protect other residents from abuse by resident #016.

c) Update and implement resident #015's care plan to ensure that they are protected from abuse by resident #016.

Regarding items a) and b) of Compliance Order #001:

Inspector #577 conducted a record review of resident #016's care plan in effect on

the date of the incident. The Inspector found that the care plan focus for specific behaviours with certain interventions by staff had been unchanged.

Inspector #577 found no updated interventions in their care plan to protect other residents from abuse, as was previously ordered with a compliance date of November 3, 2016.

Inspector #577 reviewed resident #016's Health Care Record (HCR) which revealed a document that had indicated that the resident presented with specific behaviours responsive to their environment.

Inspector #577 conducted a record review of resident #016's progress notes and found an incident where resident #016 was involved in an altercation with resident #019. Resident #016 was found to be demonstrating a responsive behaviour toward resident #019 in a common area. Resident #019 responded emotionally and verbally to the incident, was moved from the immediate area and further complained of pain related to the altercation. This incident had occurred after the compliance date of November 3, 2016, when the home was to have reviewed, revised and updated resident #016's care plan to ensure that the interventions were effective to protect other residents from resident #016.

During an interview with the current Acting DOC on November 22, 2016, they reported they had not revised and updated the care plan for resident #016 as ordered in Compliance Order #001 by November 3, 2016. [s. 19. (1)] (577)

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

Resident #026 was identified as requiring further inspection related to nutrition and hydration risk. In addition, residents #010 and #021 were also identified as requiring further inspection related to their nutrition plans of care.

Inspector #616 reviewed an assessment dated late in March, 2016, documented by the RD in resident #026's progress notes. The Inspector noted that this was the last nutrition review found in resident #026's HCR. This Inspector reviewed the HCRs for residents #010 and #021 and found that the last documented nutrition assessment for each resident was dated early in March, 2016. Within these assessments, both residents #010 and #021 were assessed by the RD to have had a specific nutrition risk level.

The home's "Long Term Care Resident Dietary Information Policy", effective date January 13, 2015, outlined that the RD reviewed all high, moderate and low nutritional risk residents quarterly, with change of status, and annually.

During an interview with the RAI Coordinator on January 5, 2017, they confirmed to the Inspector that the subsequent nutrition assessments for resident #026, #010, and #021 had been scheduled on the home's Assessment Planners but were not completed.

The Inspector reviewed the home's "Historical Shift Date Activity Report" that documented the RD hours in the home. The following calculation was used by the Inspector to determine the RD's required hours in the home:

-current number of residents in the home on November 23, 2016 = 151 residents x 30 minutes per resident = 4530 minutes or 75.5 hours per month.

During an interview with the AD on November 24, 2016, the RD's schedule was reviewed over 27 weeks related to missed nutrition assessments. The AD verified that as the RD had not been on site in the home over a period of 19 weeks, the required amount of time to carry out their clinical and nutrition care duties had not been fulfilled. [s. 74. (2)] (616)

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and their bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

During stage one of the inspection, resident #001, #006, and #007 were identified for further inspection related to potential side rail restraints.

On a day in November, 2016, Inspector #577 observed bed rails in the guard

position and resident #001 was not in bed at the time. Eight days later, Inspector #617 observed resident #001's bed when one bed rail was in the guard position, and the other was not used.

On this same day, Inspector #617 interviewed resident #001 who reported that they used the bed rail that was observed in the guard position.

Inspector #617 interviewed RPN #103, who confirmed that resident #001 used this bed rail.

The HCR for resident #001 was reviewed and there was no documentation found that indicated that the resident had been assessed in regard to bed rail use, or that their bed system was evaluated.

Inspector #617 interviewed RN #114, RPN #113, and RPN #117 who all reported that they were not aware of a bed rail use assessment or bed system evaluation that had been completed for any resident in the home who used bed rails that were not a restraint. On this day, Inspector #617 also interviewed RN #110 who reported that as part of the resident admission checklist the registered staff were to have completed the bed rail assessment form for each resident. However, the registered staff checked off "not applicable" because they had not yet been trained in completion of the form and were not aware of the home's bed entrapment prevention program.

A review of the home's policy titled, "Bed Entrapment Prevention Program", revised on September 21, 2015, indicated that the registered staff were responsible for the following:

-upon admission, re-admission and with any significant change in condition each resident was to be assessed for potential risk for entrapment on the bed (Refer to Bed Rail Assessment Form);

-the mattress condition and fit to bed frame was to be assessed (Refer to Potential Zones for Entrapment);

-the bed rail was to be assessed for reliability for latching and for stability.

Inspector #617 interviewed the current Acting DOC who reviewed the home's policy titled, "Bed Entrapment Prevention Program". They confirmed that the

registered staff were responsible to complete an assessment for potential risk for entrapment on the bed using the "Bed Rail Assessment" form; assess mattress condition and fit to bed frame using the "Potential Zones of Entrapment", and assess bed rail for reliability for latching and for stability. The Acting DOC further explained that this program had not yet been implemented for any residents in the home, and that registered staff including themself, had not yet been trained in the program. [s. 15. (1) (a)] (617)

2. On a day in November, 2016, Inspector #196 observed resident #006's bed which had one bed rail in the guard position. Five days later, Inspector #617 observed resident #006 lying in their bed with two bed rails in the guard position.

On this same day, Inspector #617 interviewed PSW #116 who reported that resident #006 used the bed rails.

The HCR for resident #006 was reviewed and no documentation was found that indicated that the resident had been assessed in regard to bed rail use, or that their bed system had been evaluated.
[s. 15. (1) (a)] (617)

3. On a day in November, 2016, Inspector #196 observed resident #007's bed which had two bed rails in the guard position. On two occasions, days later, Inspector #617 observed two bed rails in the guard position on the resident’s bed.

Inspector #617 interviewed resident #007 who reported that they used the two bed rails in the guard position.

Inspector #617 interviewed PSW #118 who reported that resident #007 used the bed rails.

The HCR for resident #007 was reviewed and there was no documentation found that indicated that the resident had been assessed in regards to bed rail use, or that their bed system was evaluated.
[s. 15. (1) (a)] (617)

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee shall ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including interventions.

A CIS report was received by the Director on a day in October, 2016, and another CIS report was received by the Director six days later, alleging inappropriate responsive behaviour from resident #002 towards resident #005.

Resident #002 had been identified in a previous inspection as having been involved in incidents of suspected abuse, including numerous separate incidents toward resident #005. Please refer to Inspection report #2016_264609_0019, WN #6, Finding #2.

A review of resident #002's care plan by Inspector #577 effective at the time of the two incidents did not contain any specific interventions related to residents at risk or interventions to maintain the resident's safety from the responsive behaviours of resident #002 by preventing or minimizing such behaviours.

Inspector #577 reviewed the current care plan for resident #002, which was in effect after the two incidents with resident #005. It included a focus to address resident #002's responsive behaviours as well as staff interventions. Two days after the second incident in October with resident #005, the care plan goal had been updated, additional strategies or interventions were developed and implemented in resident #002’s care plan.

From the date of the first reported incident in October, 2016, to the date resident #002's care plan had been updated to include strategies and interventions to respond to their behaviours, eight days had lapsed. During this time resident #005 was involved in an additional incident from resident #002.

On the same day, the Administrator (AD) further confirmed that the care plan in place at the time of the two incidents did not reflect any specific interventions for resident #002. [s. 53. (4) (c)] (616)

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care was based on, at a minimum, interdisciplinary assessment of their customary routines.

Inspector #577 interviewed resident #026 on a day in November, 2016, who reported that some staff were not respectful, and that sometimes they were not provided with privacy when performing an activity of daily living.

On November 22, 2016, Inspector interviewed PSW #109 who reported that resident #026 was known to value their privacy.

The Inspector found no assessment related to resident's #026's customary routines, specifically related to room privacy.

The Inspector interviewed PSW #111 who reviewed resident #026's care plan. They confirmed to the Inspector that resident #026 preferred to have their privacy respected by staff and that it was not indicated in their care plan. [s. 26. (3) 1.] (617)

2. The licensee has failed to ensure that a resident's plan of care was based on, at a minimum, interdisciplinary assessment of their sleep patterns and preferences.

During an interview with Inspector #577 and Inspector #617 on two separate occasions, resident #001 reported that they required assistance with bed mobility and staff assisted them too early in the morning. Resident #001 then explained to the Inspector that this was not their preference to get out of bed early.

Inspector interviewed PSW #109 who explained that they were one of a team of three PSWs that were assigned to care for residents in an area where resident #001 lived. This PSW further explained that resident #001 was routinely the first resident to be assisted out of bed by the team. Inspector interviewed PSW #112 who reported that they were assigned to the team to care for resident #001 and assisted this resident from bed at a specific time on a particular day in November, 2016. PSW #109 confirmed to the Inspector that resident #001 did not arrive to the dining room until two hours later on this particular day because staff were behind schedule.

The Inspector's found no assessment related to sleep patterns and preferences. A review of resident #001's care plan did not indicate interventions for their preferences related to sleep patterns, including when to get up in the morning.

Inspector #617 interviewed PSW #111 who confirmed resident #001's preferences related to wake times. PSW #111 reviewed resident #001's care plan and confirmed to the Inspector that the resident's sleep pattern preferences were not indicated in the resident's care plan. [s. 26. (3) 21.] (617)

3. During an interview with Inspector #577 and Inspector #617 on two separate occasions, resident #004 reported that staff assisted them out of bed too early in the morning. Resident #004 explained to the Inspector it was not their preference to get out of bed early.

Inspector interviewed PSW #109 who explained that they were one of a team of three PSWs that were assigned to care for residents in an area where resident #004 lived. This PSW further explained that resident #004 was routinely one of the first residents to be assisted out of bed by the team. Inspector interviewed PSW #112 who reported that they were assigned to the team to care for resident #004 and assisted this resident from bed at a specific time on a particular day. PSW #109 confirmed to the Inspector that resident #004 did not arrive to the dining room

until two hours later on this particular day because staff were behind schedule.

The Inspector found no assessment related to sleep patterns and preferences. A review of resident #004's care plan did not indicate interventions for their preferences or their sleep patterns on when to get up in the morning.

Inspector #617 interviewed PSW #111 who confirmed resident #004's preferences related to wake times. They confirmed to the Inspector that this resident's sleep pattern preferences were not indicated in the resident's care plan. [s. 26. (3) 21.] (617)

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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: customary routines and sleep patterns and preferences, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: communication of the seven-day and daily menus to residents.

On a day in November, 2016, Inspector #196 observed a meal service on a specific unit.

The daily menu was not posted on the unit for viewing by the residents residing in this home area.

Inspector #196 conducted an interview with DA #100 regarding the posting of the menu in the unit. They reported that families could check the menu board outside the main dining room to see what was being served or they could ask the staff and the residents could also ask the staff. An interview was conducted with the Manager, Food and Nutrition, and they reported that the residents kept removing the menus when they were posted on the unit and that it was posted outside the main dining room for families to see. In addition, the Manager told the Inspector that the family members could ask the staff what was on the menu. [s. 73. (1) 1.] (196)

2. The licensee has failed to ensure that the home had a dining and snack service

that included, at a minimum, the following elements: the provision to residents of any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

On a day in November, 2016, Inspector #196 observed a meal service on a specific unit.

Resident #011 was observed to turn over their glass and spill the contents onto the shared table. Five minutes later, the same resident was provided with a mug of soup and it was placed in their hand by a PSW. The PSW walked away and the resident turned the mug over and poured the soup onto the shared table.

Inspector #196 reviewed the HCR of resident #011. The dietary reference sheet as in the dining room, identified the resident's required level of assistance by staff. The current care plan as found in Gold Care, under the nutrition focus included the required assistance by staff during meals.

On November 17, 2016, Inspector #196 conducted an interview with the Manager, Food and Nutrition who confirmed that the dietary reference sheet identified the required level of personal assistance for resident #011. [s. 73. (1) 9.] (196)

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM), if any, and any other person specified by the resident, were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A CIS report was received by the Director in July, 2016, alleging inappropriate responsive behaviour by resident #028 towards resident #018, which had occurred 22 days earlier.

Inspector #577 reviewed that CIS report and noted that information concerning notification of resident #018's SDM was not documented.

During an interview with the current Acting DOC on November 22, 2016, they confirmed that resident #018's SDM was not notified of the incident at any time. [s. 97. (1) (b)] (577)

WN #9: 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 in making a report to the Director under subsection 23 (2) of the Act, the licensee included 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: a description of the individuals involved in the incident, including, names of all residents involved in the incident.

A CIS report was received by the Director in July, 2016, alleging inappropriate responsive behaviour of resident #028 towards resident #018, which had occurred 22 days earlier.

During a review of the CIS report, Inspector #577 found that the name of resident #018 was not included in the report.

During an interview with the Acting DOC on November 22, 2016, they confirmed that resident #018's name was not identified as required in the CIS report. [s. 104. (1) 2.] (577)

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

Inspector #616 reviewed the "Long Term Care Home Infection Prevention and Control Checklist" that had been completed by the AD. They had documented on the checklist that the home screened residents for tuberculosis (TB) using a "two-step Mantoux test" (TST). They had documented and stated to the Inspector, that in consultation with the home's Infection Control Practitioner (ICP), the home was behind in TB screening of new residents.

On November 23, 2016, the Inspector interviewed the ICP. They stated that the home's admission procedure included a two-step skin test for TB (TST) within 14 days of admission. The ICP stated that for a period of approximately six to nine months this had not been done related to a malfunction of the vaccine fridge.

The Inspector reviewed the home's Admission Long Term Care Procedure, last printed "02/04/2013", with an attached Admission Checklist. The checklist identified that on "Day One", the TB Skin Test - step 1 was to be completed. Seven to 14 days after step one results were read, step two was to be completed.

The Inspector reviewed the five most recently admitted residents' health records focusing on TST screening. Resident #024 had been admitted to the home and had not received TST screening, step one, until 19 business days later, as documented in their health care record.

During a telephone interview with the ICP on January 4, 2016, they verified that resident #024 did not have their TST screening within 14 days of admission. [s. 229. (10) 1.] (616)

Issued on this 13 day of April 2017 (A3)

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

Ministère de la Santé et des Soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
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Telephone: (705) 564-3130
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JENNIFER KOSS (616) - (A3)

Inspection No. / No de l'inspection : 2016_463616_0026 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 028562-16 (A3)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Apr 13, 2017;(A3)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_339617_0021, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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) Ensure that resident #006, #012, and #008 are provided the special dietary requirements as per their plan of care.

b) Review and revise the nutrition documentation system utilized by direct care providers at the points of service (nutrition pass and meal service) to ensure that special dietary requirements are offered and consumed. The documentation system format must allow for record of any special dietary requirements provided as per the residents' plan of care that would include but not limited to, thickened fluids, glucose polymer formula, and nutrition supplements.

Grounds / Motifs :

1. In following up on outstanding Compliance Order #001 issued during Inspection #2016_339617_0021 with a compliance date of August 31, 2016, the licensee was ordered to:

a) Establish and implement a monitoring system that ensures special dietary requirements including thickened fluids 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.

While the home completed items "b" and "c" of the order; the requirements for "a" were not met.

On a day in November, 2016, Inspector #196 observed the dining service on a specific unit.

The diet sheet for the unit was reviewed and identified that residents #012 and #008 were to receive specific nutrition interventions with their meals.

An interview was conducted with DA #100 and they reported that the DAs added the specific nutrition interventions to the residents' plated food. They confirmed to the Inspector that neither resident #012 nor resident #008 had received the nutrition interventions as identified on the diet sheet as they had forgotten to do so.

On November 17, 2016, an interview was conducted with the Manager, Food and Nutrition. They reported that the DAs were to provide the specific nutrition interventions to those residents identified on the diet sheet. (196)

2. Inspector #617 found during this inspection that resident #006 had special dietary requirements that were not offered at meals by the staff responsible to provide them in the dining room.

A review by Inspector #616 of the Registered Dietitian's (RD) assessment indicated that resident #006's nutritional risk level had been determined. Interventions to mitigate this risk were included in the plan of care.

On November 22, 2016, Inspector #616 reviewed the Dining Room Diet Sheet which indicated that resident #006 was to have specific nutrition interventions at each meal.

On a day in November, 2016, the Inspector observed resident #006 in the dining room during a meal service. Personal Support Worker (PSW) #106 was observed by the Inspector as they requested the resident's plate at the servery and then offered the prepared plate to resident #006. During this observation, one of the specific nutrition interventions was not added to the meal by the Dietary Aide (DA) at the servery nor by the PSW at meal delivery.

During an interview with PSW #106 during this supper service, they stated to the Inspector that resident #006 was not ordered any nutritional interventions with meals. They stated that if so, the information would be on the diet sheet. Inspector #616 reviewed the resident's nutritional interventions ordered on the diet sheet with PSW #106. They confirmed to Inspector #616 that this was the current diet sheet, it indicated the nutritional interventions and that they should have provided the nutrition interventions to resident #006 but had not.

On a day in November, 2016, Inspector #616 observed resident #006 during another meal service in the dining room. The resident did not have their specific nutrition interventions at their place setting on the table, and through the observation this resident was not provided this intervention by staff. PSW #107 was observed as they served the meal to resident #006 after preparation by DA #108. No specific nutrition interventions were observed to have been provided by either DA #108 or PSW #107.

During an interview with PSW #107 during the meal service, they confirmed to Inspector #616 that resident #006 had not received any nutritional interventions during the meal. PSW #107 also stated to the Inspector that the diet sheet in the dining room provided them with specific information related to diet orders. Together, the PSW and the Inspector reviewed the diet sheet for resident #006. The PSW confirmed this resident had not received either of the nutritional interventions for months.

Inspector #616 interviewed DA #108 after the meal service. They explained to the

Inspector that the DAs were responsible to provide this specific nutrition intervention to resident #006 only at the PSW's request. DA #108 confirmed to the Inspector that resident #006 had not received their nutrition intervention on this day. The DA stated that one specific nutrition intervention had not been provided to resident #006 for months, that the other nutrition intervention had not been available in the dining room for a length of time, and had not been provided to resident #006.

A review of the home's policy titled "Nutrition and Hydration Program Policy", #P-VI-3, revised on June 17, 2013, indicated that the Registered Staff were to ensure that special dietary requirements were administered as ordered by the Physician or Dietitian; and the Direct Care Staff were to record or report the resident's diet and fluid intake as directed.

On November 23, 2016, in an interview with the Manager, Food and Nutrition and the Acting Director of Care (DOC), they explained to Inspector #617 that special dietary requirements ordered by the RD for residents were to be either added or offered to the resident at each meal by the PSW and DAs in the dining room. The staff were to follow the diet sheet located in the dining room and record the volume of consumed food on the residents' nutrition intake charts. The Manager, Food and Nutrition, was unable to provide evidence that resident #006 was provided with their special dietary requirements and confirmed to the Inspector that the supply of one of the interventions had been low, would no longer be available, and had not informed the RD or the Physician to provide a substitute.

LTCHA, 2007 S.O. 2007, s. 6(7) was issued previously as:

-a CO during Inspection #2016_339617_0021,
-a WN during Inspection #2016_320612_0018, and
-a WN during Inspection #2014_380593_0007.

The decision to re-issue this compliance order was based on the scope which was a pattern, the severity which indicated potential for actual harm, and the compliance history which despite previous non-compliance (NC), NC continues with this area of the legislation. (617)

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

Ministère 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

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

Mar 10, 2017

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2016_320612_0018, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A1)
The licensee shall:

a) Ensure that all residents in the home are protected from abuse by anyone and not neglected by the licensee or staff.

b) Review, revise, and update resident #016's care plan to ensure that the interventions are implemented and effective to protect other residents from abuse by resident #016.

Grounds / Motifs :

1. Inspector #577 was following up on outstanding Compliance Order #001 issued during Inspection #2016_320612_0018 with a compliance date of November 3,

2016. The licensee was ordered to:

a) Ensure that all residents are protected from abuse by anyone and not neglected by the licensee or staff.

b) Review, revise and update resident #016's care plan to ensure that the interventions were effective to protect other residents from abuse by resident #016.

c) Update and implement resident #015's care plan to ensure that they are protected from abuse by resident #016.

Regarding items a) and b) of Compliance Order #001:

Inspector #577 conducted a record review of resident #016's care plan in effect on the date of the incident. The Inspector found that the care plan focus for specific behaviours with certain interventions by staff had been unchanged.

Inspector #577 found no updated interventions in their care plan to protect other residents from abuse, as was previously ordered with a compliance date of November 3, 2016.

Inspector #577 reviewed resident #016's Health Care Record (HCR) which revealed a document that had indicated that the resident presented with specific behaviours responsive to their environment.

Inspector #577 conducted a record review of resident #016's progress notes and found an incident where resident #016 was involved in an altercation with resident #019. Resident #016 was found to be demonstrating a responsive behaviour toward resident #019 in a common area. Resident #019 responded emotionally and verbally to the incident, was moved from the immediate area and further complained of pain related to the altercation. This incident had occurred after the compliance date of November 3, 2016, when the home was to have reviewed, revised and updated resident #016's care plan to ensure that the interventions were effective to protect other residents from resident #016.

During an interview with the current Acting DOC on November 22, 2016, they reported they had not revised and updated the care plan for resident #016 as ordered in Compliance Order #001 by November 3, 2016. [s. 19. (1)] (577)

LTCHA, 2007 S.O. 2007, s. 19 (1) was issued previously as:

-a WN during Inspection #2016_264609_0019,
-a CO during Inspection #2016_320612_0018, and
-a CO during Inspection #2014_380593_0007 (complied).

The decision to re-issue this compliance order was based on the scope which was isolated, the severity which was actual harm/risk to resident #019, and the compliance history which despite previous NC, NC continues with this area of the legislation. (577)

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

Mar 10, 2017

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Order / Ordre :

The licensee shall:

Ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

Grounds / Motifs :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

Resident #026 was identified as requiring further inspection related to nutrition and hydration risk. In addition, residents #010 and #021 were also identified as requiring further inspection related to their nutrition plans of care.

Inspector #616 reviewed an assessment dated late in March, 2016, documented by the RD in resident #026's progress notes. The Inspector noted that this was the last nutrition review found in resident #026's HCR. This Inspector reviewed the HCRs for residents #010 and #021 and found that the last documented nutrition assessment for each resident was dated early in March, 2016. Within these assessments, both residents #010 and #021 were assessed by the RD to have had a specific nutrition risk level.

The home's "Long Term Care Resident Dietary Information Policy", effective date January 13, 2015, outlined that the RD reviewed all high, moderate and low nutritional risk residents quarterly, with change of status, and annually.

During an interview with the RAI Coordinator on January 5, 2017, they confirmed to the Inspector that the subsequent nutrition assessments for resident #026, #010, and #021 had been scheduled on the home's Assessment Planners but were not completed.

The Inspector reviewed the home's "Historical Shift Date Activity Report" that documented the RD hours in the home. The following calculation was used by the Inspector to determine the RD's required hours in the home:

-current number of residents in the home on November 23, 2016 = 151 residents x

30 minutes per resident = 4530 minutes or 75.5 hours per month.

During an interview with the AD on November 24, 2016, the RD's schedule was reviewed over 27 weeks related to missed nutrition assessments. The AD verified that as the RD had not been on site in the home over a period of 19 weeks, the required amount of time to carry out their clinical and nutrition care duties had not been fulfilled. [s. 74. (2)] (616)

LTCHA, 2007 S.O., Reg. 79/10, s. 74(2) was issued previously as:

-a CO during Inspection #2014_339579_0016 (complied).

The decision to issue this compliance order was based on the scope which was a pattern, the severity which was potential for actual harm/risk, and the compliance history which despite previous NC, NC continues with this area of the legislation. (616)

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

Mar 31, 2017(A2)

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

(A2)
The licensee is required to prepare, submit and implement a plan for achieving compliance under O. Reg. 97/10, s. 15 (1). This plan is to include:

a) Strategies to be taken to ensure that where bed rails are used, all residents receive an assessment, and bed rail use to be included in the plan of care.

b) A plan to ensure that all staff receive training in the long-term care home's policy to assess bed rail use and entrapment risk of residents and annual retraining thereafter.

The plan is to be submitted to Jennifer Koss, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care Inspection Branch, via email at SudburySAO.moh@ontario.ca by March 24, 2017.

Grounds / Motifs :

(A3)
1. On a day in November, 2016, Inspector #196 observed resident #007's bed which had two bed rails in the guard position. On two occasions, days later, Inspector #617 observed two bed rails in the guard position on the resident??s bed.

Inspector #617 interviewed resident #007 who reported that they used the two bed rails in the guard position.

Inspector #617 interviewed PSW #118 who reported that resident #007 used the bed

rails.

The HCR for resident #007 was reviewed and there was no documentation found that indicated that the resident had been assessed in regards to bed rail use, or that their bed system was evaluated.

Inspector #617 interviewed RN #114, RPN #113, and RPN #117 who all reported that they were not aware of a bed rail use assessment or bed system evaluation that had been completed for any resident in the home who used bed rails that were not a restraint. On this day, Inspector #617 also interviewed RN #110 who reported that as part of the resident admission checklist the registered staff were to have completed the bed rail assessment form for each resident. However, the registered staff checked off "not applicable" because they had not yet been trained in completion of the form and were not aware of the home's bed entrapment prevention program.

A review of the home's policy titled, "Bed Entrapment Prevention Program", revised on September 21, 2015, indicated that the registered staff were responsible for the following:

-upon admission, re-admission and with any significant change in condition each resident was to be assessed for potential risk for entrapment on the bed (Refer to Bed Rail Assessment Form);

-the mattress condition and fit to bed frame was to be assessed (Refer to Potential Zones for Entrapment);

-the bed rail was to be assessed for reliability for latching and for stability.

Inspector #617 interviewed the current Acting DOC who reviewed the home's policy titled, "Bed Entrapment Prevention Program". They confirmed that the registered staff were responsible to complete an assessment for potential risk for entrapment on the bed using the "Bed Rail Assessment" form; assess mattress condition and fit to bed frame using the "Potential Zones of Entrapment", and assess bed rail for reliability for latching and for stability. The Acting DOC further explained that this program had not yet been implemented for any residents in the home, and that registered staff including themself, had not yet been trained in the program. (617)

(A3)
2. On a day in November, 2016, Inspector #196 observed resident #006's bed which had one bed rail in the guard position. Five days later, Inspector #617 observed resident #006 lying in their bed with two bed rails in the guard position.

On this same day, Inspector #617 interviewed PSW #116 who reported that resident #006 used the bed rails.

The HCR for resident #006 was reviewed and no documentation was found that indicated that the resident had been assessed in regard to bed rail use, or that their bed system had been evaluated.
(617)

(A3)
3. On a day in November, 2016, Inspector #577 observed bed rails in the guard position and resident #001 was not in bed at the time. Eight days later, Inspector #617 observed resident #001's bed when one bed rail was in the guard position, and the other was not used.

On this same day, Inspector #617 interviewed resident #001 who reported that they used the bed rail that was observed in the guard position.

Inspector #617 interviewed RPN #103, who confirmed that resident #001 used this bed rail.

The HCR for resident #001 was reviewed and there was no documentation found that indicated that the resident had been assessed in regard to bed rail use, or that their bed system was evaluated.

LTCHA, 2007 S.O., Reg. 79/10, s. 15 (1)(a) was issued previously as:

-a WN and VPC during Inspection #2016_246196_0001,
-a WN during Inspection #2014_339579_0016.

The decision to issue this compliance order was based on the scope which was a pattern, the severity which was potential for actual harm/risk, and the compliance history which despite previous NC, NC continues with this area of the legislation.
(617)

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

Mar 31, 2017(A2)

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall:

Ensure that for resident #002 and all other residents demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments, and interventions and that the resident's responses to interventions are documented.

Grounds / Motifs :

1. The licensee shall ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including interventions.

A CIS report was received by the Director on a day in October, 2016, and another CIS report was received by the Director six days later, alleging inappropriate responsive behaviour from resident #002 towards resident #005.

Resident #002 had been identified in a previous inspection as having been involved in incidents of suspected abuse, including numerous separate incidents toward resident #005. Please refer to Inspection report #2016_264609_0019, WN #6,

Finding #2.

A review of resident #002's care plan by Inspector #577 effective at the time of the two incidents did not contain any specific interventions related to residents at risk or interventions to maintain the resident's safety from the responsive behaviours of resident #002 by preventing or minimizing such behaviours.

Inspector #577 reviewed the current care plan for resident #002, which was in effect after the two incidents with resident #005. It included a focus to address resident #002's responsive behaviours as well as staff interventions. Two days after the second incident in October with resident #005, the care plan goal had been updated, additional strategies or interventions were developed and implemented in resident #002's care plan.

From the date of the first reported incident in October, 2016, to the date resident #002's care plan had been updated to include strategies and interventions to respond to their behaviours, eight days had lapsed. During this time resident #005 was involved in an additional incident from resident #002.

On the same day, the Administrator (AD) further confirmed that the care plan in place at the time of the two incidents did not reflect any specific interventions for resident #002. [s. 53. (4) (c)] (616)

The decision to issue this compliance order was based on the scope which was isolated, the severity which indicated actual harm/risk by resident #002, and the history of unrelated non-compliance in the last three years. (616)

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

Mar 10, 2017

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

Ministère 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

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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 13 day of April 2017 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JENNIFER KOSS - (A3)

Service Area Office /
Bureau régional de services : Sudbury