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
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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
May 17, 2017	2017_435621_0011	004330-17, 004333-17, 004360-17, 004363-17, 004364-17	Follow up

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

JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 18, 19, 20, 21, and 24, 2017.

Critical Incident System (CIS) Inspection #2017_435621_0012 was conducted concurrently with this inspection.

This Follow Up inspection was related to follow up of past due compliance orders issued in Resident Quality Inspection report #2016_463616_0026 (A3) which included:
Compliance Order (CO) #001 related to one intake for s.6(7) Plan of Care; CO #002 related to one intake for s.19(1) Prevention of Abuse and Neglect; CO #003 related to one intake for r.74(2) Registered Dietitian Hours; CO #004 related to one intake for r.15(1) Bed Rail Assessments; and CO #005 related to one intake for r.53(4) Responsive Behaviours.

A finding of non-compliance related to LTCHA, s.6(7) found during the concurrent CIS inspection report #2017_435621_0012 was issued in this report.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental Services Manager, Nutrition Manager (NM), Activity Coordinator, Activity Aide, Food Services Supervisor (FSS), Registered Dietitian (RD), Resident Assessment Instrument (RAI) Coordinator, residents and their families.

The Inspector also reviewed resident health records, employee training records, staff schedules, and the home's policies and procedures. The Inspector also completed observations of residents, observed provision of care and services to residents, and observed resident to resident and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 WN(s)
1 VPC(s)
1 CO(s)
1 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
O.Reg 79/10 s. 15. (1)	CO #004	2016_463616_0026	621
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2016_463616_0026	621
O.Reg 79/10 s. 53. (4)	CO #005	2016_463616_0026	621
O.Reg 79/10 s. 74. (2)	CO #003	2016_463616_0026	621

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. 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 resident #016 as specified in the plan.

Inspector #621 followed up on an outstanding Compliance Order #001 issued during inspection report #2016_463616_0026 (A3) with a compliance date of March 10, 2017. While the licensee complied with the details of the order, a subsequent finding of non-compliance for s.6(7) was identified as part of the concurrent Critical Incident System (CIS) inspection #2017_435621_0012, and was issued in this report.

Inspector #621 reviewed a Critical Incident System (CIS) report, submitted to the Director on a day in January 2017, for an incident of resident to resident abuse between resident's #016 and #030, which resulted in injury to resident #030 on an earlier day in January 2017.

Inspector #621 completed a review of resident #016’s health records after the January 2017, incident, and identified a further incident of responsive behaviours on another date in April 2017. Documentation identified that RPN #112 witnessed resident #016 exhibit responsive behaviours towards resident #037. RPN #112 also reported that Personal Support Worker (PSW) #116, who had been assigned specifically to resident #016, was not present with this resident at the time of the incident.

The Inspector reviewed the care plan in effect when the April 2017 incident occurred, which identified that resident #016 required specific interventions, which included, a type of staff monitoring, and that staff were to ensure a Dementia Observation System (DOS) was completed.

During an interview with RPN #112 on another day in April 2017, they verified to the Inspector that they had witnessed the April 2017, incident between resident #016 and #037, and confirmed that PSW #116 was the staff person assigned to resident #016, and that they were not monitoring this resident at the time of the incident and should have been.

On the same day in April 2017, Inspector #621 reviewed resident #016's DOS records between March and April 2017, and observed the DOS was incomplete for all dates.

During an interview on a day in April 2017 with RPN #113, they reported to the Inspector that since a specified date in January 2017, DOS charting was to be completed on resident #016 to track resident behaviours, and that monitoring on the DOS record was to be completed at specific intervals. RPN #113 confirmed to the Inspector that the DOS records were missing documentation for all specified dates between March and April 2017.

During an interview with the DOC on a specific date in April 2016, they identified to Inspector #621 that it was their expectation that staff provide care as outlined in resident #016’s plan of care, which included completion of DOS monitoring and documentation, and provision of specific assigned staff. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”. DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: 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.

The home had a compliance order (CO) from report #2016_463616_0026(A3) for LTCHA, 2007 S.O., Reg. 79/10, s.74(2) with a CO due date of March 31, 2017. The non-compliance identified within this report occurred prior to the CO due date.

Inspector #621 reviewed copies of the Registered Dietitian (RD) calendar provided by the home for February and March of 2017, which documented the RD onsite service hours. It was identified that the RD provided a total of 60 hours during February 2017, and 67.5 hours in March 2017. The following calculation was used by the Inspector to determine the RD's required hours in the home:

Resident census = 164 residents x 30 minutes per month = 4920 minutes or 82 hours per month.

During an interview with the Registered Dietitian (RD) on a specific day in April 2017, they reported to Inspector #621 that for 164 residents, they were required to provide approximately 11 days or 82.5 hours of onsite service time to the home per month. The RD reported that in February 2017, they provided eight days or 60 hours, and in March 2017, they provided nine days or 67.5 hours of onsite RD service time. The RD further reported that the home met with the licensee prior to the compliance order due date, and a review was completed of the RD's workload so that from April 2017, onward, the home would be providing the required onsite RD time to meet legislative requirements.

During an interview with the DOC on a specific date in April 2017, they reported to the Inspector that they had meetings with the licensee to reorganize the RD schedule across all sites and identified that it was their expectation that the home provide a minimum of 30 minutes of onsite RD time per resident per month. They confirmed that for February and March 2017, the home did not meet the onsite RD time requirement. [s. 74. (2)]

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 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, to be implemented voluntarily.

Issued on this 19th day of May, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2017_435621_0011
Log No. / Registre no:	004330-17, 004333-17, 004360-17, 004363-17, 004364-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 17, 2017
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

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_463616_0026, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 for every resident in the home, staff provide care as specified in each resident's plan of care, including the planned care for resident #016 with respect to responsive behaviour management; and

b) Develop and implement an auditing process to ensure care is provided as per the resident's plan of care.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #016 as specified in the plan.

Inspector #621 followed up on an outstanding Compliance Order #001 issued during inspection report #2016_463616_0026 (A3) with a compliance date of March 10, 2017. While the licensee complied with the details of the order, a subsequent finding of non-compliance for s.6(7) was identified as part of the concurrent Critical Incident System (CIS) inspection #2017_435621_0012, and was issued in this report.

Inspector #621 reviewed a Critical Incident System (CIS) report, submitted to the Director on a day in January 2017, for an incident of resident to resident abuse between resident's #016 and #030, which resulted in injury to resident #030 on an earlier day in January 2017.

Inspector #621 completed a review of resident #016's health records after the January 2017, incident, and identified a further incident of responsive behaviours on another date in April 2017. Documentation identified that RPN #112 witnessed resident #016 exhibit responsive behaviours towards resident #037. RPN #112 also reported that Personal Support Worker (PSW) #116, who had been assigned specifically to resident #016, was not present with this resident at the time of the incident.

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During an interview with the DOC on a specific date in April 2016, they identified to Inspector #621 that it was their expectation that staff provide care as outlined in resident #016's plan of care, which included completion of DOS monitoring and documentation, and provision of specific assigned staff. [s. 6. (7)]

LTCHA, 2007 S.O. 2007, s.6(7) was issued previously as:
- a CO during inspection #2016_463616_0026 (A3) with a CO due date of March 10, 2017;
- a CO during inspection #2016_339617_0021 with a CO due date of August 31,

2016;
- 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 severity which indicated potential for actual harm, the scope which was isolated for care not being provided as set out in the plan of care for resident #016, and the compliance history which in spite of previous compliance orders, there was continued non-compliance with this area of the legislation. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 07, 2017

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

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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
Ontario, ON
M5S-2B1
Fax: 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 17th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Kuorikoski

Service Area Office /
Bureau régional de services : Sudbury Service Area Office