Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 17, 2017	2017_435621_0012	001352-17, 004008-17, 006599-17	Critical Incident System

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 Critical Incident System inspection.

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

Follow Up inspection #2017_435621_0011 was conducted concurrently with this inspection.

Logs that were inspected include:
Two intakes related to critical incidents the home submitted regarding alleged resident to resident abuse; and
One intake related to a critical incident the home submitted regarding a medication error.

A finding of non-compliance related to LTCHA, s.6(7), found during this inspection was issued under Follow Up report #2017_435621_0011.

During the course of the inspection, the inspector(s) spoke with the 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, the home's policies and procedures, employee files, and home's investigation notes. 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:
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #025 that set out the planned care for the resident.

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

During a review of resident #030's documentation between March and April 2017, Inspector #621 identified a specified number of incidents of responsive behaviours during April 2017, where resident #025 was witnessed by RPNs #102 and #112 to exhibit responsive behaviours towards resident #030.

During an interview with RPN #102 on a specific day in April 2017, they identified that resident #030 generally did not demonstrate responsive behaviours except during certain activities of daily living, or in a specific situation. RPN #102 further reported that there there had been an increase in behaviours with resident #025 in April 2017 with a specific number of incidents where resident #025 initiated responsive behaviours towards resident #030. Additionally, RPN #102 identified that resident #025's substitute decision maker (SDM) identified that a result of their personal history, resident #025 exhibited more responsive behaviours towards certain residents in specific circumstances, including resident #030.

During an interview with the DOC on a specific day in April 2017, they reported to the

Inspector that as part of resident #025's responsive behaviour management, they had added an intervention of monitoring resident #025 over a specified duration, utilizing specific staff, and verbally notified staff that this intervention would begin on a specific shift during a day in April 2017.

On another specific day in April 2017, Inspector #621 completed a review of resident #025's plan of care and identified that there had been no care plan update on or after a specific day in April 2017, to identify that an intervention of monitoring, which utilized specific staff over a particular time period, was initiated with resident #025, or that staff were responsible to provide specific monitoring and anticipate responsive behaviours from resident #025 towards specific residents, including resident #030.

During an interview with RPN #113 on a specific day in April 2017, they reported to Inspector #621 that planned interventions for responsive behaviour management of resident #025 would be found in the resident's care plan located in the resident's chart and electronic health record. RPN #113 identified that additional interventions including monitoring with assignment of specific staff, over a particular time period, was initiated with resident #025 starting on another day in April 2017, and that staff were to monitor for responsive behaviours from resident #025 towards specific residents, including resident #030 in certain circumstances, before responsive behaviours resulted.

During a review of resident #025's care plan, last updated on a specified day in April 2017, RPN #113 reported to Inspector #621 on another day in April 2017, that resident #025's written care plan did not set out the planned care for this resident with regards to specific monitoring and utilization of specific staff over a particular time period, or monitoring and separation resident #025 from specific residents, including resident #030, in certain circumstances, and should have.

During an interview with DOC on a day in April 2017, they identified to Inspector #621 that it was their expectation that there was a written plan of care for resident #025, which set out the planned care for this resident's responsive behaviours. [s. 6. (1) (a)]

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 there is a written plan of care for resident #025 that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug was administered to resident #025 in accordance with the directions for use specified by the prescriber.

A Critical Incident System (CIS) report was submitted to the Director on a day in February 2017, related to a medication incident involving resident #025 on another day in February 2017.

A review of the home's investigation notes identified that RPN #100 had taken resident #025's medication card and checked it to the Medication Administration Record (MAR), but had become distracted by another resident and returned resident #025's medication card to the wrong place in their cart. Consequently, when RPN #100 resumed medication pass for resident #025, they pulled another resident's medication card from the cart and gave resident #025 a dose of the identified medication from it instead, which resulted in resident #025 receiving an incorrect amount of the prescribed medication.

On a day in April 2017, Inspector #621 reviewed resident #025's MAR and the corresponding physician's order which documented a certain medication to be given on a particular schedule, at a specified dose, to resident #025.

During an interview with RPN #102 on the same day in April 2017, they reported to the Inspector that it was the RPN’s responsibility when performing a medication pass to compare the resident identifiers on the medication card to the resident's MAR to ensure it was the right resident, before removing the pills, and administering to the resident. RPN #102 reported that they were aware of the incident and stated that the RPN responsible had gotten distracted with another resident during medication pass, and on their return to administering medications, pulled a medication card for another resident by mistake, and hadn't performed a check to ensure the medication card information matched resident #025's MAR. Consequently, RPN #102 identified that RPN #100 would have not been able to ensure the medication they were administering was the right dose for the right resident. RPN #102 further identified that it wasn’t until a specific activity was completed that the error was found.

During an interview with the DOC on a specified day in April 2017, they reported to Inspector #621 that it was their expectation that registered staff who administer prescribed medication, completed as part of their standards of practice, all required checks before dispensing a medication to a resident. The DOC confirmed that the home’s investigation concluded that resident #025 was administered a wrong dose of a specific medication on a date and time in February 2017, which was not in accordance with what was prescribed. [s. 131. (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 drug administered to resident #025 is in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

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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.