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

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
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 10, 2017	2017_435621_0016	009326-17, 009661-17, 010921-17	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): June 5 - 9, 2017.

A Complaint Inspection #2017_435621_0018 and an Other Inspection #2017_435621_0017 were conducted concurrently with this inspection.

This Critical Incident System (CIS) Inspection was completed related to:
One intake related to a critical incident the home submitted regarding an incident of resident to resident abuse;
One intake related to a critical incident the home submitted regarding an incident of alleged staff to resident neglect; and
One intake related to a critical incident the home submitted regarding a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Activation Aides, a Psychogeriatric Resource Consultant (PRC), the interim Director of Care (DOC), the interim Administrator and residents of the home.

The Inspector observed resident interactions, as well as staff to resident interactions, and reviewed documentation including the home's investigation files, resident health records and various programs, policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 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 :

The licensee has failed to ensure that residents were protected from abuse and free from neglect by the licensee or staff.

Inspector #621 reviewed a Critical Incident System (CIS) report, which was submitted to the Director on a specific day in June 2017 for an incident of suspected neglect of resident #012. The CIS report indicated that on the same day in June 2017, RPN #126 found resident #012 unattended in their mobility aid. It was reported that RPN #126 brought resident #012 to a specific location, alerted the Registered Nurse (RN) on duty, with the resident assessed for a specific medical condition. It was identified that a specific diagnostic test was taken and resident #012 was found to have results above normal limits. Subsequently, the report identified resident #012 was taken to hospital for a specified medical intervention.

The Inspector reviewed resident #012’s care plan utilized at the time of the incident, which identified that this resident used a mobility aid and required portering from staff to meet their locomotion needs. Additionally, a review of this resident’s electronic health record identified resident #012 had three relevant medical diagnoses requiring routine staff monitoring.

O.Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

During an interview on as specific day in June 2017, Activation and Restorative Care Aide (ARCA) #114, reported to Inspector #621 that there were a total of five areas at the home, that were locked unless there were favorable conditions, and/or a family member requested and was present to take a resident to a specific location with their supervision. ARCA #114 identified that the specific areas of the home when opened, were only open during a specific time frame each day, and PSW staff were responsible to unlock these areas on one specified shift and lock them on a later specified shift. Further, ARCA #114 reported that residents who had specific mobility or medical conditions were to have a staff person present and supervising those residents while they were in the specified area, to ensure their safety and meet the residents' care needs. ACRA #114 indicated that on a specifc day in June 2017, resident #012 had been seated with a specified number of other residents in a particular area.

During an interview on another day in June 2017, RN #129 and RPN #107, reported to

Inspector #621 that on an earlier day in June 2017, resident #012 was taken to a specific area of the home. When the Inspector asked about the process for monitoring residents in this area, RN #129 and RPN #107 identified that no specific PSW was assigned monitoring duties of the specified area that day as the monitoring assignment schedule had not been updated, and subsequently the record for monitoring of residents in that specific area was not completed at specific intervals that day. They indicated that at a specific time on the day of the incident, RPN #110 notified unit staff coming on duty for a specified shift, that resident #012 was still seated in a particular area of the home. RN #129 and RPN #107 further reported that PSW #127 had checked on resident #012 at a specific time thereafter, but not again at regular intervals before resident #012 was found in distress at a specific time by RPN #126. RN #129 indicated that reflecting on resident #012's medical conditions and mobility needs, that when resident #012 communicated to PSW #127 at a particular time, the desire to stay in the specific area of the home, PSW #127 should have notified one of the registered nursing staff to come and assess the resident at that time.

During an interview on a specific day in June 2017, interim Administrator #100, reported to Inspector #621 that their investigation identified that a specified monitoring record had not been completed at specific time intervals as no PSW had been assigned the duty on the day of the incident. Interim Administrator #100 identified that as a result, resident #012 had been left unsupervised for a specific time interval which was more than the expected time intervals for monitoring the specified area of the home. The interim Administrator acknowledged that the home had failed to protect resident #012 from neglect. [s.19. (1)]

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 residents are protected from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #621 reviewed a Critical Incident System (CIS) report that was submitted to the Director on a specific day in May 2017, for an incident of alleged resident to resident physical abuse which caused injury. The incident was identified to have occurred on a specific time of day in May 2017, however the report was submitted to the Director one day later.

During an interview on a day in June 2017, interim Director of Care (DOC) #101, reported to Inspector #621 that registered staff reported the incident to them immediately, however, they had submitted the CIS report the next day. When the Inspector asked the reason for the late submission, the interim DOC reported that they were unfamiliar with the CIS reporting software and in error, saved the CIS instead of submitting it.

During an interview on a day in June 2017, with the interim Administrator, they reported to Inspector #621 that it was their expectation that any alleged, suspected or witnessed incident of abuse or neglect was reported to the Director immediately. [s. 24. (1)]

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 person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or risk of harm to the resident, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, where possible.

Inspector #621 reviewed a Critical Incident (CI) report, which was submitted to the Director on a day in May 2017, for an incident of resident to resident physical abuse causing injury.

According to the CI report, during a specific time and day in May 2017, RN #108, RPN#135 and PSW #126 discovered resident #009 in a specific area of the home, with resident #016 demonstrating a specific responsive behaviour towards them, which

resulted in injury of resident #009.

During a review of resident #016's progress notes between specific dates in May and June 2017, Inspector #621 identified a subsequent incident of responsive behaviours between resident #016 and #009.

During an interview on a specific day in June 2017, PSWs #133, 138, #139 reported to Inspector #621 that resident #009 was a known trigger for resident #016's responsive behaviours due to their own specific behaviours as a result of a medical condition. Additionally, PSWs #133, #138 and #139 reported that incidents between these two residents had occurred since resident #009 was admitted to the unit in the winter of 2016.

Inspector #621 reviewed resident #016's written plan of care, last revised on a day in April 2017, and identified that the care plan for this resident's responsive behaviours had not been updated following the May 2017, incident between resident #016 and #009 which resulted in injury to resident #009, or at any other time thereafter.

A review of the home's policy titled "Responsive Behaviours", with no policy number, and last print date in August 2013, identified under the procedures for registered nursing staff, that they were to identify the cause, triggers and level of risk associated with responsive behaviours of residents at all levels of escalation.

During an interview on a day in June 2017, RPN #111 reported to Inspector #621 that the plan of care, which included the written care plan were updated by the Resident Assessment Instrument (RAI) Coordinator quarterly, and registered nursing staff at least every six months, or when care needs of a resident changed. Additionally, RPN #111 confirmed to the Inspector that an altercation causing injury of resident #009 had occurred on a specific day in May 2017, that resident #009 was known to exhibit certain behaviours that were a potential trigger for resident #016's physically responsive behaviours.

RPN #111 reviewed resident #016's written care plan for "Responsive Behaviours", last revised in April 2017, and confirmed to the Inspector that this resident's care plan had not been updated after the May 2017, incident between resident #016 and #009 that resulted in injury to resident #009, or any other time thereafter. RPN #111 also confirmed that there was no intervention in resident #016's care plan identifying resident #009 was a potential trigger for physical responsive behaviours from resident #016 when resident

#009 exhibited certain behaviours, and should have been.

During an interview on a specific day in June 2017, interim Administrator #100 reported to Inspector #621 that it was their expectation that for residents demonstrating responsive behaviours, behavioural triggers for the resident were identified and documented as part of their plan of care. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible, to be implemented voluntarily.

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that resident #016 was reassessed and the plan of care was reviewed and revised at least every six months or at any other time when the care set out in the plan was not effective.

Inspector #621 reviewed a Critical Incident Systems (CIS) report which was submitted to the Director on a specific day in May 2017, for an incident of physical abuse between resident #016 and resident #009, which caused injury to resident #009.

During a review of resident #016's plan of care, including their written care plan, last revised in April 2017, it identified that staff were to ensure a specific safety device was positioned in a specified location of the home. Additionally, the care plan identified that the specific safety device had been removed by resident #016, that it was located in another area of the home, and no longer being used as intended.

On a day in June 2017, Inspector #621 observed that no safety device was in place in the location that resident #016's care plan identified.

During an interview on a day in June 2017, RPN#111 reported to Inspector #621 that the use of a specific safety device as part of resident #016's plan of care had proved ineffective and was no longer being used.

RPN #111 reviewed resident #016's care plan, last revised in April 2017, and confirmed that the care plan was still identifying use of the specific safety device, and should not have.

During an interview on a day in June 2017, interim Administrator #100, identified that it was their expectation that registered nursing staff review and revise resident plans of care at least every six months, or at any time when care set out in the plan was not effective. [s. 6. (10) (b)]

Issued on this 10th day of July, 2017

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

Original report signed by the inspector.