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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 10, 2018	2017_624196_0017	017176-17, 017299-17, 021945-17	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

LAUREN TENHUNEN (196), KATHERINE BARCA (625)

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): November 20 - 24, 2017.

This Critical Incident System (CIS) Inspection was conducted as a result of the following three critical incident system (CIS) reports, the home submitted to the Director, in which
- one report related to a resident fall which resulted in an injury;
- one report related to an incident of resident to resident physical abuse; and
- one report related to alleged incident of staff to resident abuse.

Complaint inspection #2017_624196_00018 and Follow Up inspection 2017_624196_0016 were inspected concurrently. As a result, findings of non-compliance related to LTCHA 2007, S.O.2007, c.8, s.6.(7) identified during the CIS inspection will be issued in the Follow Up report.

During the inspection, the Inspectors conducted a walk through of resident care areas, observed staff to resident interactions, observed the provision of care and services to residents, reviewed various home's policies, procedures and training records, and reviewed resident health care records.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Resident Assessment Instrument (RAI) Coordinator, the Nurse Practitioner [RN (EC)], the Wound Care Lead, the Environmental Services Manager (ESM), a Therapeutic Recreationist, residents and family members.

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.

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was submitted to the Director in 2017, for an incident of suspected staff to resident abuse or neglect. The report identified that resident #004 was found to had a change in their skin integrity.

Inspector #625 reviewed the electronic progress notes from an approximate three month time period in 2017, with a focus on the change in the resident's skin integrity. The following was identified:
- on a specific date in 2017, RN (EC) #104 indicated a possible cause;
- on a subsequent date in 2017, resident #004’s physician suggested another possible cause; and
- on another date in 2017, the DOC had discussion with staff aimed at minimizing further change in skin integrity.

Inspector #625 reviewed resident #004’s current care plans including:
- Physical Restraints, that stated, specific concerns; and
- ADL Assistance, that stated the type of transfer and assistance required.

A review of the home’s policy titled, “Minimal Lift Procedures– BA-VI-4.2.32”, effective November 29, 2016, indicated that, in order to select the correct sling, staff were to identify the goal of each transfer, including the determination that the goal of a transfer was for repositioning.

During an interview with RPN #111, they stated to Inspector #625 that they were not sure how the altered skin integrity to resident #004 had occurred but it could have been caused by staff potentially adjusting the resident using a specific technique. The RPN stated that if staff had to adjust the resident, they could use a specific technique.

During an interview with PSW #112, they demonstrated to the Inspector how they would manually reposition resident #004 in their ambulation device. The PSW demonstrated and verbalized the process. The PSW stated that they had worked in the home for a specified number of years and received training on lifts, transfers and positioning upon hire and when new lift equipment was implemented for use in the home. With respect to ongoing training on positioning techniques, the PSW stated that PSW #113 would "come around with a paper to sign saying [the PSW] had seen us do it, or does it with us".

During interviews with PSWs #114 and #115, they demonstrated and verbalized to Inspector #625 how they manually repositioned resident #004 in their ambulation device. PSW #114 stated that they had worked in the home for a specific number of years and had been trained on lifts, transfers and repositioning on hire and when new equipment was introduced into the home. PSW #115 stated they had worked in the home for a specified number of years, and had been trained on the use of mechanical lifts and transfer techniques/repositioning by PSW #113 when hired.

During interviews with PSWs #116, #117, #118, and #119, they indicated to Inspector #625 that resident #004 required a particular device for repositioning in their ambulation device. PSW #118 also stated that it would be impossible for staff to manually reposition a different way.

During an interview with Inspector #625, DOC #101 stated that staff should have used a particular device and lift apparatus to reposition resident #004 in their ambulation device. The DOC stated that the one and two person manual repositioning techniques observed by the Inspector were not appropriate as they could result in altered skin integrity or injury to the resident. The DOC stated that annual training was provided to staff by PSW #113, the training should have included repositioning of resident in their chairs, but they were not sure of the content of the training. [s. 36.]

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 that ensures staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: 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. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that, if not everything required under subsection (1) could be provided in a report within 10 days, the licensee made a preliminary report to the Director within 10 days and provided a final report to the Director within a period of time specified by the Director [21 days].

As identified in WN #1, a CIS report was submitted to the Director in 2017, for an incident of suspected staff to resident abuse or neglect.

The CIS report was amended by the home on a specific date and indicated that a review by the RN (EC) identified a possible medical condition that may have contributed to the resident's change in skin integrity. The amended report identified that the RN (EC) concluded the resident was subject to this change in skin integrity for a specific reason.

During an interview with Inspector #625, the RN (EC) reviewed the electronic progress note they had documented; confirmed that the resident's change in skin integrity had been caused by the resident positioning themself and their possible medical condition. The RN(EC) also stated that the physician had assessed the resident following the RN (EC).

Inspector #625 reviewed the electronic progress notes entered by the resident's physician dated:
- on a specific date in 2017, which noted an assessment of the altered skin integrity, and questioned the cause; and
- on a subsequent date, that stated, the DOC had discussion with staff aimed at minimizing further change in skin integrity.

During an interview with Inspector #625, DOC #101 stated that they had spoken to the resident's physician who did inform the DOC that they believed the altered skin integrity was not the result of a specific medical condition, but was caused by another reason. The DOC stated that they did not update the CIS report to the Director to include the physician's opinion of the cause of the altered skin integrity, although the opinion differed from the cause previously submitted to the Director in the report amended on another date. The DOC acknowledged that they should have updated the report with the current information obtained from the resident's physician. [s. 104. (3)]

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 that ensures if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director (21 days), to be implemented voluntarily.

Issued on this 12th day of January, 2018

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

Original report signed by the inspector.