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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 10, 2018	2017_624196_0018	021236-17, 021713-17	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): November 20 - 24, 2017.

The following intakes were inspected:

A complaint related to staffing concerns and an allegation of staff to resident abuse.

A complaint related to a resident fall.

A Critical Incident System (CIS) inspection #2017_624196_00017 and a 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 Complaint 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 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:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

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

2 WN(s)
1 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. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, if the Family Council had advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee responded to the Family Council within ten days of receiving the advice.

A complaint was received by the Director related to a specific type of staffing coverage, the quality of care provided to resident #006, a resident fall resulting in injury, and the suitability of the home for residents with responsive behaviours.

During an interview with the complainant, they stated that they had brought forward safety concerns through the Family Council, specific to the physical environment on one of the homes' units.

During a second interview with the complainant, the specific dates of the maintenance safety concerns identified to the licensee by the Family Council were provided to Inspector #625. The complainant stated that:
- During a Rainycrest Family Council Meeting in the winter of 2017, they brought up specific concerns. They were told by the previous Administrator #108 that they were required to complete written complaint forms in order to have the concerns addressed.
- The day following the meeting, they completed and submitted two separate written complaint forms. The complainant stated they did not receive a written response with respect to either complaint.
- During the following Rainycrest Family Council Meeting, they discussed that a specific concern would be repaired in the spring.
- During the following Rainycrest Family Council Meeting they discussed a specific concern on one of the homes' units.
- At the following Rainycrest Family Council Meeting they again discussed the same

specific concern on one of the homes' units.
- In the fall of 2017, Rainycrest Family Council Meeting again discussed the same specific concern on one of the homes' units. At this meeting, the Family Council provided a list to the home, titled, "Health and Safety Concerns at Rainycrest Home for the Aged" and dated the list. The list contained items carried forward as well as additional health and safety concerns related to maintenance in the home.
- During the following Rainycrest Family Council Meeting, they again discussed, and referred to the Health and Safety Concerns from the dated list and added an additional concern on a specific home unit.
- During the late fall Rainycrest Family Council Meeting they discussed the status of specific concerns on one of the homes' units. They referred to the Health and Safety Concerns from the previous meeting and stated that very little had been done to address the list that had been presented to the Director of Care (DOC) #101 during previous Family Council meetings. The complainant stated that they requested a report as to management's intentions on rectifying the items remaining on the list.

Inspector #625 reviewed the Rainycrest Family Council Meeting minutes and/or agendas for the meetings discussed with the complainant. The content captured in the documents were consistent with the details provided by the complainant during the interview.

Inspector #625 reviewed two written complaints that the complainant submitted to the home in the winter of 2017. Both written complaints identified that they had been discussed at one of the Family Council Meetings in the winter of 2017.

Inspector #625 reviewed a document titled, "Rainycrest Family Council Meeting Health and Safety Concerns at Rainycrest Home for the Aged". The document identified carry over health and safety concerns, as well as additional health and safety concerns related to different areas of the home.

During an interview with Inspector #196, DOC #101 stated that they had received the, "Health and Safety Concerns at Rainycrest Home for the Aged" from the Family Council meeting. The DOC stated that they had provided the document to Environmental Services Manager (ESM) #109 on the date it was received to address the concerns but had not responded to the Council in writing regarding the concerns that had been brought up at the meeting. [s. 60. (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 that ensures that, if the Family Council had advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee responded to the Family Council within ten days of receiving the advice, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A complaint was received by the Director related to the care provided to resident #005.

Inspector #625 reviewed resident #005's care plan titled Activity of Daily Living (ADL) Assistance, which identified that the resident required specific staff assistance.

The Inspector also reviewed the Bath Schedules (Days and Evenings) for one of the homes' units. The schedule indicated resident #005 received a bath on two particular shifts, on two specific days.

A review of resident #005's PSW Flow Sheets for a specific month in 2017, identified that staff were to, "…fill out each shift using appropriate letters for all sections except cognitive patterns and mood behaviours. Use R if resident refuses care and H if resident is in hospital. Use a code of 8 if activity did not occur." The Inspector identified that staff had not completed documentation as required during the night shifts on ten occasions in a particular month in 2017; during the day shifts on two occasions in the same month in 2017; and during the evening shifts on nine occasions, in the same month, in 2017. The staff had not completed the required shiftly documentation of care during 21 out of 66 shifts, or 32 per cent of the shifts. In addition, the staff had not documented that resident #005 had received a bath during the day shift on one particular day in 2017.

During an interview with resident #005, they stated to the Inspector that they had received a bath on that particular day in 2017.

During an interview with PSW #110, they stated to the Inspector that they had bathed resident #005 on that particular day in 2017, during the day shift but had not yet documented the bath, as the end of the shift was busy with staff responding to call bells. The PSW also stated that the PSW Flow Sheets for resident #005 should have had documentation for each shift to indicate the care that was provided. The PSW acknowledged that there were multiple shifts during the particular month in 2017 that did not have the provision of care to the resident documented.

During an interview with Inspector #625, DOC #101 acknowledged that the provision of care as set out in the plan of care for resident #005 had not been documented on the PSW Flow Sheets during the particular month in 2017. [s. 6. (9) 1.]

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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.