Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Inspections Branch

Ministère de la Santé et des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Name of Director:	Karen Simpson
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 **X** Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 □ Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	2018_509617_0004
Licensee:	Riverside Health Care Facilities Inc. 110 Victoria Avenue Fort Frances ON P9A 2B7
LTC Home:	Rainycrest 550 Osborne Street Fort Frances ON P9A 3T2
Name of Administrator:	Marva Griffiths

Background:
On February 20, 2018, as part of inspection 2018_509617_0004, two Director's Referrals were made in accordance with s.152, paragraph 4 of the *Long-Term Care Homes Act*, 2007 *(LTCHA)* to Riverside Health Care Facilities Incorporated. Director's Referral #001 was issued for failure to comply with O. Reg. 79/10, s. 31 (3) (the section of non compliance was amended from s.31(2) to s.31(3) in the Inspection and Order reports as the wrong section was inputted into the system, the reasoning supports s.31(3). Director's Referral #002 was issued for failure to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. (1); specifically, for failure to protect residents from neglect. Despite previous findings of non-compliance issued to the licensee with respect to s. 19 of the *LTCHA*, including three compliance orders and two voluntary plans of correction issued in the last 36 months, non-compliance has continued.

This is the fourth time that Riverside Health Care Facilities Incorporated has been issued a Director's Referral since May 2017. As part of the Director's Referrals, the Director has considered the scope and severity of the non-compliance identified in inspection 2018_509617_0004, along with the licensee's history of compliance, and has determined that it is necessary to issue this Order.

Order:	

To Riverside Health Care Facilities Incorporated, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to the following Legislative and Regulatory requirements:

1) O. Reg. 79/10, s. 31(3) The licensee shall ensure the home's staffing plan must,

a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
b) set out the organization and scheduling of staff shifts;
c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

2) O. Reg. 79/10, s. 219(4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
a) hand hygiene; O. Reg. 79/10, s. 219 (4).
b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

3) O. Reg. 79/10, s. 229(6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

4) O. Reg. 79/10, s. 229(7) The licensee shall implement any surveillance protocols given by the Director for a particular communicable disease. O. Reg. 79/10, s. 229 (7).

5) O. Reg. 79/10, s. 229(9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

6) *LTCHA*, 2007 S.O. 2007, c.8, 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).

Order:

1) To bring in a consultant from an external company with extensive experience in managing or operating long-term care homes to conduct a review and make recommendations for improvement regarding the following:

a) The nursing program within the home to ensure that it is organized to meet the assessed needs of the residents, including 24 hour nursing care;

b) The program of personal support services for the home to ensure that it is organized to meet the assessed needs of the residents;

c) The staffing plan within the home to ensure that it meets the assessed needs of residents and is evaluated and updated as necessary.

d) The Infection Prevention and Control (IPAC) Program to ensure that there is an outbreak management system for detecting, managing and controlling infectious disease outbreaks, including staff responsibilities, reporting protocols based on requirements under the *Health Protection and Promotion Act*, and communication protocols for receiving and responding to health alerts.

e) The Skin and Wound Care Program to ensure that it provides for routine skin care to prevent wounds, strategies to promote the prevention of infection, including monitoring of residents, and strategies to transfer and position residents.

f) The home's policy to minimize the restraining of residents and its implementation.

g) The organized program of maintenance services in the home, including all resident lift equipment, bath and tub room facilities and their associated fixtures.

2) Upon completion of the review, the findings and recommendations will be set out in a report which will be provided by the consultant to both the licensee and the Director under the Act. This review and the findings must be completed no later than April 30, 2018.

Within two weeks of receiving the report, the licensee will submit a plan to the Director identifying the recommendations that will be implemented and the timelines for implementation. That plan will be reviewed by the Director and may be changed based on the Director's review of the report and the plan submitted by the licensee. Upon approval of the plan by the Director, the licensee will implement the recommendations and any action(s) identified by the Director.

3) To prepare and implement a plan to provide in-person training for staff on the appropriate implementation of the IPAC Program, in accordance with the requirements of the LTCHA and O. Reg. 79/10.

4) To prepare and implement a plan to provide in-person training for staff on the prevention of abuse and neglect, including what constitutes abuse and neglect, mandatory reporting obligations and the licensee's policy to promote zero tolerance of abuse and neglect in accordance with the requirements of the LTCHA and O. Reg. 79/10.

All of the plans are to be submitted to Karen Simpson, Director, by fax to 613-569-9670 or courier to 347 Preston Street, Suite 420, Ottawa, Ontario, K1S 3J4 by May 15, 2018

Grounds:

This Order is necessary given the scope and severity of the non-compliance identified in inspection #2018_509617_0004, outlined below. This Order is being issued to ensure that the licensee addresses the serious and on-going non-compliance identified below by taking the actions identified by the Director in this Order, in addition to the actions identified by inspectors in the five compliance orders (CO#001, #002, #003, #004 and #005) issued following Inspection #2018_509617_0004, in order to achieve compliance.

As Director, I have relied on the evidence gathered in Inspection #2018_509617_0004. I have reviewed the inspection report, the Orders issued and the evidence collected by the inspector. I have also reviewed the inspectors' analysis of the scope, severity and the compliance history associated with the non-compliance identified.

Based on this, I have determined that this Director's Order is warranted given that non-compliance with LTCHA, 2007, S.O. 2007, c. 8, s. 19(1) and O. Reg. 79/10, s. 31(3) was found, the evidence gathered, the inability of the licensee to achieve compliance and the additional non-compliance with the LTCHA identified as part of inspection #2018_509617_0004. Additional non-compliance that was found includes, but is not limited to, the licensee's failure to train and re-train staff in IPAC practices and implement those practices, and ensuring that a resident's plan of care is based on an assessment of the resident, including requirements when restraining a resident. This Director's Order is being issued considering the compliance history of the licensee with respect to the legislative requirements identified below. Given the significant number of findings of non-compliance, poor compliance history and staffing instability, the licensee has demonstrated that it cannot identify corrective actions or develop a plan to address the non-compliance. Therefore, an external consultant is required to review and make recommendations so that that the licensee can adopt them to address the non-compliance (through a plan).

Given the significant number of findings of non-compliance, poor compliance history and staffing instability, the licensee has demonstrated that it cannot identify corrective actions or develop a plan to address the non-compliance. Therefore, an external consultant is required to review and make recommendations so that the licensee can implement the recommendations through a plan, to address the non-compliance.

Evidence demonstrating the recent staffing instability and the requirement for an external consultant is provided in inspection report #2018_509617_0004 and includes the following:

- Between October 1, 2017, and January 31, 2018, 16 employees had their employment terminated, 11 of whom had resigned
- In December 2017, insufficient staffing resulted in 607 Personal Support Worker (PSW) hours unfilled, subsequently in January 2018, an additional 628 PSW hours went unfilled.
- Scheduled baths for residents were not given
- Snack and fluid passes were not done

- Call bells were not answered for long periods of time
- Mechanical lift transfers were performed by one staff member
- Evidence of an increase in altered skin integrity identified; a specific number of residents on each of the three units had a new skin breakdown
- A resident experienced a fall as a result of a lack of staff available to intervene in the responsive behaviours of a resident's actions toward another co-resident.

Inspection report #2018_509617_0004 further identified the licensee's failure to implement outbreak management process in consideration of the LTCHA and O. Reg. 79/10:

- The home failed to notify the Public Health Unit of the detected presence of infection trends.
- The home failed to ensure that annual diagnostic tests were completed in preparation for a potential an outbreak of a reportable communicable disease, leading to a delay in the administration of a specific medication.
- The home failed to ensure that hand sanitizer supplies were readily available to staff, visitors, and residents.
- The home failed to provide IPAC training, as only 57 per cent of the staff had completed training in hand hygiene.

The areas of non-compliance issued in inspection #2018_509617_0004 and that are relevant to this Order are detailed below. Direction is being provided in this Order to ensure that the licensee takes action, in addition to the actions ordered by the Inspectors, to address the following areas of non-compliance:

- In response to non-compliance related to **O. Reg. 79/10, s. 31 (3)**:

  The Director has ordered the licensee to obtain an external consultant to initiate a review of the nursing, personal support services program in the home to ensure they are structured to meet the needs of the residents. In addition, the licensee is ordered to ensure the staffing plan is reviewed to ensure it meets the needs of residents and their assessed care needs. Upon review, the licensee will be required to act on any recommendations from that review.

- Staffing shortages detailed in the inspection report impacted multiple areas of resident care, as noted above. They were not isolated to a specific resident care concern or a specific unit within the home. A review of the PSW staffing payroll hours and the summary of nursing shortage hours indicated that for the month of December 2017, the home worked 607 PSW hours short, and for the month of January 2018, the home worked 628 PSW hours short. A review of the summary of nursing shortage hours indicated that every day for the months of December 2017, and January 2018, the home worked a range of 5 to 55 hours short. Work load concerns related to staff working without a full complement of PSW staff were brought to the Director of Nursing and Personal Care. Despite the administration team's awareness of the staffing shortages occurring, the licensee did not put in place appropriate strategies or actions to address the staffing shortage, which negatively impacted resident care.

Two PSW staff told the Inspector that they had worked alone on a specific unit during a nightshift in January 2018. Both PSWs indicated that they were responsible to provide care for 56 residents by themselves on these night shifts. As a result, they used the mechanical lift by themselves in the morning when residents required toileting assistance. They were unable to answer call bells in a timely manner; they both expressed concern for the residents' safety as residents had to wait for assistance for continence related transfers.

- The Ministry received multiple complaints related to staffing shortages impacting resident care and upon inspection, non-compliance was identified. The non-compliance and evidence to support it is detailed in the inspection report. In one case, one of the residents said that a specific resident frequently wandered into their room and they were afraid of this resident. They further explained that this same resident wandered into their room and there was no staff to help them get the resident out of their room. The resident tried to stand up from their wheelchair, fell, and were injured.

In interviews with two family members, they reported to the Inspector that they were concerned about the staffing "crisis" in the home and that the residents' care needs were not being met. They explained that over the past year, they had attended several Family Council meetings in which concerns were raised by the Council regarding the staffing shortages that were occurring resulting in the residents' call bells not being answered in a timely manner, which put the residents at risk, and that resident baths were being missed. At one of the Family Council meetings, the DOC indicated that resident care needs were not being met due to the staffing shortage.

Given the issues above and outlined in more detail in the inspection report, the licensee has not put in place strategies to effectively address the requirements of the LTCHA to ensure that there is a staffing mix that is consistent with the residents' assessed care and safety needs. It is for these reasons that I am ordering the licensee to bring in an external consultant with expertise in long-term care to analyse the current staffing plan and prepare recommendations, as the licensee has not been able to put in place strategies to effectively address the issues themselves.

- In response to non-compliance related to **O. Reg. 79/10, s. 229. (6)**:

The Director has ordered the licensee to obtain an external consultant to initiate a review of the Infection Prevention and Control (IPAC) Program to ensure that there is an outbreak management system for detecting, managing and controlling infectious disease outbreaks, including staff responsibilities, reporting protocols based on requirements under the *Health Protection and Promotion Act*, and communication protocols for receiving and responding to health alerts in accordance with the requirements of the LTCHA and O. Reg. 79/10.

This is required because of the licensee's failure to appropriately implement IPAC practices in accordance with O. Reg. 79/10. In accordance with O. Reg. 79/10, s. 229 (5), the licensee shall ensure that on every shift, symptoms indicating the presence of infection in residents are to be monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and, the symptoms are to be recorded and immediate action taken. The licensee failed to ensure that the information gathered under subsection (5) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends for the purpose of reducing the incidence of infection and outbreaks.

- A complaint was sent to the Director with regards to an active outbreak in the home. In an interview with the complainant, they clarified that on a specific date, staff identified that a large number of residents were sick with a reportable communicable disease and that this was not reported to the Public Health Unit until the next day.

- A Public Health Inspector confirmed that they were in contact with the home and were not aware of the line listings that occurred on on three specific days. A line listing tracks residents who have been identified with similar symptomology. When more than three residents with similar symptomology are identified, this information is shared with the local Public Health Unit. The Public Health Inspector explained that if they were notified of these cases, at the time, they would have called an Infection Control Meeting with the home, and possibly called an outbreak of a reportable communicable disease sooner, in accordance with the *Public Health Act*.

- In response to non-compliance related to **O. Reg. 79/10, s. 229 (7)**:

The Director has ordered the licensee to obtain an external consultant to initiate a review of the IPAC Program to ensure that there is an outbreak management system for detecting, managing and controlling infectious disease outbreaks, including staff responsibilities, reporting protocols based on requirements under the *Health Protection and Promotion Act*, and communication protocols for receiving and responding to health alerts., in accordance with the requirements of the LTCHA and O. Reg. 79/10.

- This action by the licensee is being required because of the licensee's failure to appropriately implement IPAC practices in accordance with O. Reg. 79/10. In accordance with O. Reg. 79/10, s. 229 (6), the licensee failed to implement any surveillance protocols given by the Director for a particular communicable disease.

As further detailed within the Inspeciton report, the Director received a complaint on a specific date, regarding several areas of concern involving the home's protection and management of residents during the recent outbreak of a reportable communicable disease. The complainant indicated that particular diagnostic tests were not performed in advance; as a result, the

provision of a specific medication for residents during an outbreak of a reportable communicable disease was delayed.

The Infection Control Practitioner confirmed to the Inspector that due to the annual diagnoostic tests not being completed, 44 per cent of the residents were delayed in receiving a specific medication during an outbreak of a reportable communicable disease.

- The DOC confirmed to the Inspector that they did not follow up to ensure that the annual diagnoostic tests required to administer a specific medication to the residents was completed; as a result, medication administration for some residents was delayed.

- In response to non-compliance related to **O. Reg. 79/10, s. 229. (9)**:

The Director has ordered the licensee to obtain an external consultant to initiate a review of the IPAC Program to ensure that there is an outbreak management system for detecting, managing and controlling infectious disease outbreaks, including staff responsibilities, reporting protocols based on requirements under the *Health Protection and Promotion Act*, and communication protocols for receiving and responding to health alerts, in accordance with the requirements of the LTCHA and O. Reg. 79/10.

- This action by the licensee is being required because the licensee failed to ensure that there was in place a hand hygiene program in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

A complainant reported that an Inspector from the Public Health Unit identified that there was a lack of hand sanitizer available for staff to use.

The reportable communicable disease outbreak meeting minutes indicated that the home was out of product for hand sanitizer dispenser refills; pump bottles of sanitizer distributed for the wall sanitizer dispensers were not accessible and were expired. The board of health had been advised and were considering putting the home under an order and fine. The Environmental Services Manager, Public Health Inspector, and the Infection Control Practitioner were in attendance at this meeting.

The Public Health Inspector stated to the Inspector that they were concerned with a gap in the process in which the hand sanitizers were monitored and replaced, lack of urgency from the home to ensure that they had an overstock of supply and the pump bottles of sanitizer used in place of the wall sanitizers were expired.

- In response to non-compliance related to **O. Reg. 79/10, s. 219. (4) (a)**:

The Director has ordered the licensee to obtain an external consultant to initiate a review of the IPAC Program to ensure that there is an outbreak management system for detecting,

managing and controlling infectious disease outbreaks, including staff responsibilities, reporting protocols based on requirements under the *Health Protection and Promotion Act*, and communication protocols for receiving and responding to health alerts, in accordance with the requirements of the LTCHA and O. Reg. 79/10. In addition, the licensee is required to ensure that all staff is trained in the home's IPAC Program.

- This action by the licensee is being required because the licensee failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the LTCHA included, hand hygiene and use of personal protective equipment.

  The home submitted a critical incident report regarding a reportable communicable disease outbreak that was declared by the Public Health Unit. The report indicated that a specific number of residents were symptomatic of a reportable communicable disease. During this time, only 57 per cent of the staff had completed the training on hand hygiene and Personal Protective Equipment.

  An RPN reported to the Inspector that due to the staffing shortage, the home required the PSWs to complete their re-training for 2017 online on their own time as there was not enough staff to backfill the shifts for the staff to complete the training at the facility.

- In response to non-compliance related to **LTCHA, 2007, S.O. 2007, c. 8, s. 19(1).**

  The Director has ordered the licensee to obtain an external consultant to prepare and implement a plan to provide in-person training for staff on the prevention of abuse and neglect, including what constitutes abuse and neglect, mandatory reporting obligations and the licensee's policy to promote zero tolerance of abuse and neglect in accordance with the requirements of the LTCHA and O. Reg. 79/10.

- This is being required because the licensee failed to ensure that residents were not neglected by the licensee or staff by, failing to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents as detailed in inspection report #2018_509617_0004.

  Report #2018_509617_0004 describes that due to insufficient staffing, residents were not provided with baths at least twice weekly, call bells were not attended to in a reasonable time, resulting in residents not receiving a specific intervention. Further, a fall resulted from the lack of staff available to intervene in the responsive behaviour of a resident resulting in an injury; scheduled nourishment was not always provided, and there was evidence of increased rates of altered skin integrity.

  Report #2018_509617_0004 also indicated that the licensee exhibited a pattern of inaction in the management of the IPAC Program. A Public Health Inspector stated that they would have

called an Infection Control Meeting with the home, and possibly declared the outbreak of a reportable communicable disease sooner, in accordance with the *Public Health Act*., Due due to the annual diagnoostic tests not being completed, 44 per cent of the residents were delayed in receiving a specific medication during an outbreak of a reportable communicable disease. There was a lack of appropriate hand sanitization equipment available to residents, staff and visitors to the home. Finally, the home failed to ensure that infection prevention and control training was provided to all staff.

Other Enforcement Actions

Since February 2015, 22 inspections have been conducted at the home. A total of 97 areas of non-compliance were identified during this time period. A total of 53 voluntary plans of correction, 23 compliance orders, and 4 Director's referrals were issued to the home.

1) On January 10, 2018, during Critical Incident System inspection #2017_624196_0017 two written notifications and two voluntary plans of correction were served to the home.
2) On January 10, 2018, during Complaint inspection #2017_624196_0018 two written notifications, and one voluntary plan of correction were served to the home.
3) On January 10, 2018, during Follow-up inspection #2017_624196_0016 four written notifications, four compliance orders and on Directors referral was served to the home.
4) On September 13, 2017, during Resident Quality Inspection #2017_463616_0011 six written notifications, two voluntary plans of correction and three compliance orders were served to the home.
5) On July 27, 2017, during an Other inspection #2017_435621_0017 one written notification, one voluntary plan of correction, and one compliance order was served to the home.
6) July 10, 2017, during Complaint inspection #2017_435621_0018 one written notification and one voluntary plan of correction was issued to the home.
7) July 10, 2017, during Critical Incident System inspection #2017_435621_0016 four written notification, and three voluntary plans of correction were issued to the home.
8) May 17, 2017, during Critical Incident System inspection #2017_435621_0012 two written notifications and two voluntary plans of correction were issued to the home.
9) May 17, 2017, during Follow up inspection #2017_435621_0011 two written notifications, one voluntary plan of correction, one compliance order, and one Director's referral was issued to the home.
10) April 13, 2017, during Critical Incident System inspection #2017_395613_0001 seven written notifications, and five voluntary plans of correction were issued to the home.
11) April 03, 2017, during Complaint inspection #2017_395613_0002 one written notification was issued to the home.
12) February 17, 2017, during Resident Quality Inspection #2016_463616_0026 ten written notifications, one voluntary plan of correction, and five compliance orders were issued to the home.
13) October 06, 2016, during Complaint inspection #2016_264609_0019 six written notifications, and five voluntary plans of correction were issued to the home.

14) October 06, 2016, during Complaint inspection #2016_320612_0018 nine written notifications, five voluntary plans of correction, and two compliance orders were served to the home.
15) October 03, 2016, during Critical Incident System inspection #2016_320612_0019 two written notifications were issued to the home.
16) October 03, 2016, during Follow up inspection #2016_320612_0017 no non-compliance was issued.
17) September 02, 2016, during Critical Incident System inspection #2016_264609_0022 no non-compliance was issued.
18) August 02, 2016, during Critical Incident System inspection #2016_339617_0021 two written notifications, one voluntary plan of correction, and one compliance order was issued to the home.
19) February 14, 2016, during Resident Quality Inspection #2016_246196_0001, 23 written notifications and two voluntary plans of correction were issued to the home.
20) July 23, 2015, during Complaint inspection #2015_246196_0005 no non-compliance was issued.
21) July 10, 2015, during Critical Incident System inspection #2015_339617_0004 four written notifications, and three voluntary plans of correction was issued to the home.
22) June 03, 2015, during Follow up inspection #2015_401616_0003 no non-compliance was issued to the home.

As Director, I am relying on the extensive history of non-compliance outlined in 22 of the inspections reports. The key areas of non-compliance, including numerous Compliance Orders and Director's Referrals included in the aforementioned inspection reports also demonstrate the licensee's inability to attain compliance with the LTCHA and O. Reg. 79/10.

This order must be complied with by:	May 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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.

Issued on this 12th day of March, 2018.	
Signature of Director:	
Name of Director:	Karen Simpson

Version date: 2017/02/15