Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
May 25, 26, & 27, 2011	2011_106_8608_25May153402	Complaint Log# S-001223-11

Licensee/Titulaire
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(s)
Margot Burns-Prouty (#106)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspector(s) spoke with: The Administrator, Director of Nursing, Registered Nursing Staff (RN and RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s): Conducted a walk-through of all resident home areas and various common areas, observed care provided to residents in the home, reviewed electronic plan of care, reviewed written plans of care, reviewed progress notes, and interviewed staff members.

The following Inspection Protocols were used:

- Falls Prevention
- Medication
- Minimizing of Restraining

☒ Findings of Non-Compliance were found during this inspection.

9 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 31(2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Findings:

1. A resident is documented as using a pelvic restraint from March 28, to April 8, 2011. A signed consent form, by the SDM, was found in resident's chart for use of a wander guard, but there was no signed consent form allowing the use of a pelvic restraint found.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8., s.6 (1) (c) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. In the plan of care for a resident in the section titled Risk of Injury from Falls, there is only one intervention which states, "issued w/c PRN", this lone interventions does not give frontline staff clear direction as to when it is appropriate to use the wheelchair.
2. In the plan of care for a resident in the section titled Cognitive Loss/Dementia, it contains an intervention that states, "Monitor regularly and adjust treatment strategies to ensure resident's safety". This intervention does not provide clear direction to staff as it does not define "regularly" so staff would know how often to monitor the resident.

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, 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,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

Findings:

1. A resident's plan of care, under the section titled, ADL Assistance, there is an intervention that states, " TRANSFERRING: Needs no assistance"
2. During the period of time, from March 29, 2011 to April 9, 2011, where progress note indicate the resident was being transferred with a ceiling lift, there is no documentation found to support that the resident was reassessed and the plan of care reviewed and revised when their care needs changed in regards to their ability to transfer.

WN #4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c8. s. s.6(7). The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:

1. In the plan of care for a resident the section titled ADL Assistance contains an intervention that specifies, "TRANSFERRING: Needs no assistance"
2. On March 29, 2011, a progress note indicates that a sit to stand lift was used to transfer a resident; this mode of transfer is not specified in their plan of care.
3. On April 9, 2011, a progress note indicates that the ceiling lift was used to transfer a resident; this mode of transfer is not specified in their plan of care.

WN #5: The Licensee has failed to comply with O. Reg. 79/10, s.110(2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

Findings:

1. The restraint record for a resident was reviewed and there is no documentation found to indicate that the resident's pelvic restraint was monitored, by a member of the registered nursing staff or another member of staff as authorized by a member of the registered nursing staff for that purpose, during the following times:
    - March 28, 2011 - 0700 to 1500
    - March 29, 2011 - 0300 to 0600
    - March 29, 2011 - 1400 to 2200
    - March 30, 2011 - 1500 to 2200
    - March 31, 2011 - 0700 to 2300
    - April 1, 2011 - 0700 to 2200
    - April 2, 2011 - 1500 to 2300
    - April 3, 2011 - 1500 to 2300
    - April 4, 2011 - 1500 to 2300
    - April 6, 2011 - 0700 to 2300
    - April 7, 2011 - 0700 to 1600

WN #6: The Licensee has failed to comply with O. Reg. 79/10, s.110(2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)

Findings:

1. On March 30, 2011, between the hours of 0000 and 0700 the restraint record for a resident indicates that their pelvic restraint was checked every hour until the device was removed at 0800. There is no documentation to support that they were released from the pelvic restraint or repositioned at any time during above mentioned hours.

WN #7: The Licensee has failed to comply with O. Reg. 79/10, s.110(2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Findings:

1. The March 29, 2011, MARs for a resident was reviewed and the evening and night boxes that indicate that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class or a member of the registered nursing staff, were unsigned.
2. The March 30, 2011, MARs for a resident was reviewed and the evening and night boxes that indicate that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class or a member of the registered nursing staff, were unsigned.
3. The April 2011, MARs for a resident was not filled out appropriately, the DOC stated that the MARs for pelvic restraint should have three boxes for each day (titled, D, E, N). The registered staff is to sign the box each shift this will indicate that they have assessed the resident and they have made a clinical

decisions if the resident required a restraint that shift.

4. The April MARs for a resident were reviewed and for the pelvic restraint there was one line titled PRN. It was signed only once on each of the following days, April 2, 3, 4, 5, and 8, 2011, there is no indication that the resident's condition was reassessed and the effectiveness of the pelvic restraint was evaluated by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every 8 hours or at any other time when necessary based on the resident's condition or circumstances.
5. The April MARs for a resident were reviewed and there was no signature found for April 1, 6, and 7, 2011, to indicate that the resident's condition was reassessed and the effectiveness of the pelvic restraint was evaluated only by a physician, a registered nurse in the extended class or a member of the registered nursing staff at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

WN #8: The Licensee has failed to comply with O. Reg. 79/10, s.110(7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
2. What alternatives were considered and why those alternatives were inappropriate.

Findings:

1. A review of a resident's chart was conducted and no documentation was found that indicate that alternatives were considered or attempted to prior to restraining a resident with a pelvic restraint and why the alternatives were inappropriate.

WN #9: The Licensee has failed to comply with O. Reg. 79/10, s.49(2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Findings:

1. A resident was not assessed using a clinically appropriate assessment instrument for falls they sustained on March 27 and 28, 2011. The home's Director of Care stated that every fall must be documented on the homes post falls tracking sheet, which she stated was the homes post falls assessment tool specifically designed for falls. These falls were not documented on the home's post falls tracking sheet..

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). July 20, 2011