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

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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
Aug 20, 2018	2018_655679_0021	015105-18	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

MICHELLE BERARDI (679), JULIE KUORIKOSKI (621), 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): July 16-20, and 23-26, 2018.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection: One intake related to resident to resident abuse and two intakes related to alleged staff to resident abuse.

A Complaint inspection #2018_655679_0020 and a Follow Up Inspection #2018_655679_0022 were conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physician, Registered Nurse Unit Coordinator, Infection Prevention and Control Practitioner, Chief Executive Officer (CEO) of Novo Peak Health, Financial Services, Occupational Health and Safety Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Administrative Assistant, Receptionist, Physiotherapy Assistants, Personal Support Workers (PSWs), Canadian Mental Health Association Outreach PSW, Support Workers, family members and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, manufacturer instructions, as well as relevant policies.

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

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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 :

1. The licensee has failed to ensure that the responsive behaviour program was evaluated annually.

Inspector #679 reviewed a Critical Incident (CI) report submitted to the Director for an incident of resident to resident physical abuse.

A review of the policy titled "Responsive Behaviours" revealed that the policy was last updated on January 11, 2013. The policy identified that staff were to "evaluate and annually update the policy and procedures to ensure best practices are being followed".

In an interview with Inspector #679, the DOC identified that the home was currently working on a revision of the responsive behaviour policy. The DOC identified that the last approved revision to the policy was completed on January 11, 2013. [s. 53. (3) (b)]

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

A Critical Incident (CI) report was submitted to the Director for an incident of resident to resident physical abuse. The CI report identified that resident #003 performed an action towards resident #008 resulting in injury.

Inspector #679 reviewed a care document which was in place at the time of the incident. The document identified that staff were to implement a specific intervention.

In separate interviews with PSW #107, PSW #101 and RPN #102, they all identified a specific trigger for resident #003.

A review of the policy titled "Responsive Behaviours- Registered Nurse Procedure" dated January 11, 2013, identified that the staff were to identify the causes and triggers for the resident's behaviours, and to collaborate with the interdisciplinary team to develop a comprehensive plan of care with interdisciplinary goals and strategies to ensure resident well-being and quality of life and resident safety based on assessment findings.

In an interview with Inspector #679, the DOC identified the known triggers for resident #003. Inspector #679 and the DOC reviewed the electronic care plan in place at the time of the incident and could not identify any indication of the identified triggers. The DOC identified that a residents trigger should be identified in the 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 ensuring that for any resident demonstrating responsive behaviours, that the behavioural triggers for the resident are identified where possible, 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. (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 :

1. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #679 reviewed resident #003's medical record, which contained a specified document. The document identified that staff were to implement a specific intervention.

In an interview with Support Worker #113, they identified that resident #003 used to require the specific intervention, however, no longer required the intervention.

In an interview with ADOC #111 they identified that resident #003 required a specified intervention in the past. ADOC #111 reviewed the resident's paper chart and identified that the intervention was discontinued on a specific date.

In an interview with the DOC they identified that the resident's plan of care was to be updated whenever "something needed to be changed". The DOC confirmed that the statements directing the staff to complete the specified intervention should have been removed from the plan of care. [s. 6. (10) (b)]

Issued on this 19th day of September, 2018

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

Original report signed by the inspector.