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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 8, 2019	2019_679638_0011	003507-19, 005373-19	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

RYAN GOODMURPHY (638)

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): April 2 - 4, 2019.

The following intakes were completed in this critical incident system inspection:
-One log was related to an incident where a resident was found on the floor entrapped in their mobility aid; and
-One log was related to an incident where resident care was allegedly neglected by staff.

A Complaint inspection #2019_679638_0009, was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, Director of Resident Care (DORC), Assistance Director of Resident Care (ADOC), Restorative Care Aide (RCA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector also conducted a daily tour of home areas, observed the provision of care and services to residents, reviewed relevant personnel files, licensee policies, procedures, programs and health care records.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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	Légende 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Neglect is defined in the Ontario Regulation (O. Reg.) 79/10, as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A CIS report was submitted to the Director which indicated that resident #001 was found lying on the floor on a specific date at a specific time. Upon reviewing the CIS report, it was identified that a PSW charted that specific scheduled care was provided by another staff member, but upon investigating, it was identified that the resident did not receive their scheduled care, had attempted to transfer from their mobility aid and sustained a fall.

Inspector #638 reviewed resident #001's health care records and identified a care plan intervention which outlined that the resident required specific staff assistance for transferring, required specific staff assistance with personal hygiene, was supposed to be monitored on a set routine to ensure comfort and that the resident had a preferred time that they retired to bed. The resident's care plan also outlined that staff were to ensure that the resident's call bell was within reach.

The Inspector reviewed the investigation notes completed by the acting Administrator. The notes identified that PSW #102 found resident #001 on the floor, in their room, at a specific time (over two hours later than their preferred bedtime). The notes outlined an interview with PSW #111, which indicated that there was no PSW specifically assigned to certain resident care assignments on that shift. The PSW stated that four PSWs were gathered at the desk completing their charting and that there was miscommunication that resident #001's care had been completed, so they signed off the charting as done. The investigation notes further identified that RN #110 stated they felt this was neglect.

The Inspector reviewed the "Post Fall Screening Tool" completed after the incident occurred. The assessment indicated that the resident's call bell was not in reach. The Inspector reviewed resident #001's progress notes and identified a notation created around the time of the incident, which stated all staff members who responded were in agreement that if the resident had received their scheduled care and was helped into bed, the fall would not have occurred.

During an interview with Inspector #638, PSW #101 stated that PSWs were responsible for the majority of resident care and that they were kept aware of resident needs through their Point of Care (POC), which outlined the specific care for each resident. The PSW indicated that resident #001 was dependent on staff for specific care.

In an interview with Inspector #638, PSW #111 indicated that they completed documentation on resident #001 on the shift leading up to the incident. The PSW indicated that they were short staffed and that there was miscommunication about the resident. The PSW also stated that they completed a round between two hours prior to the incident, but did not think to open resident #001's door to check on them. The PSW stated that it was a "total mistake on our part" and that they completed documentation as a group because no one was specifically assigned to the vacant PSW shift assignments and nobody ensured care was complete prior to documentation because no one was specifically assigned to that resident. PSW #111 indicated the last time they recalled observing resident #001 was at approximately three hours prior to the incident. The PSW stated that they were supposed to ensure care was done prior to documenting, but felt that short staffing caused this incident to occur.

Inspector #638 interviewed RPN #103, who indicated that they responded to resident #001 when they fell. The RPN indicated that the resident had not received any of their specific scheduled care. The RPN indicated the resident was normally in bed hours before the incident occurred and indicated all care should have already been completed. The RPN further indicated that a round to check on the residents was supposed to be done at a specific time and stated that if the resident was checked on, staff would have seen that the resident was not cared for up to that point.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01" Last updated April 2017, defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In an interview with Inspector #638, the acting Administrator indicated that registered staff were supposed to re-assign residents when working short to ensure that each resident was assigned and that on the date of the incident, all staff just worked together to get their care done without specifically assigning certain residents due to the short staffing. Upon reviewing the incident, investigation notes, care plan requirements and outcomes, the acting Administrator indicated that the lack of action towards resident

#001 was considered neglect. [s. 20. (1)]

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 to ensure that resident #001 and all other residents are safe from neglect and staff comply with the home's policy to promote zero tolerance of abuse and neglect, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A CIS report was submitted to the Director related to an incident where resident #002 had slid out of their mobility aid and was found sitting on the floor and entrapped in a specific device. The CIS report identified that the resident's mobility aid was noted to be missing the proper mobility aid device cover.

Inspector #638 reviewed resident #002's health care records and identified that the resident required a specific mobility aid. The Inspector reviewed the resident's progress notes and identified a notation created one day after the incident by RCA #112. The progress note identified that all of the specific components for this specific mobility aid device were supposed to have a cover on them, because without it, the device could be slippery and may cause a fall.

The Inspector reviewed the investigation notes, which identified that they suspected improper care because the resident was in their mobility aid prior to the incident and that

the specific mobility aid device was not fastened snuggly and the proper cover was not on, which allowed the resident to slide from their mobility aid and to the floor.

In an interview with Inspector #638, PSW #104 indicated that they found the resident on the floor with a specific device entrapping the resident to their mobility aid. The PSW indicated that they identified the resident's specific mobility aid device cover was not on the mobility aid device and stated they believed that is how the resident slid out of their mobility aid. The PSW indicated that the specific cover was required because it kept the device straight and prevented the a specific part of the mobility aid device from sliding around on the base of the mobility aid.

During an interview with Inspector #638, RN #106 indicated that they responded to resident #002, when notified by PSW #104. The RN indicated that they noticed the resident's specific mobility aid device cover was not on the mobility aid device at the time of the incident and that they slid off the base of the mobility aid while still sitting on the cushion. The RN stated that without the specific mobility aid device cover, there was no friction to maintain a proper position on the base of the mobility aid.

Inspector #638 interviewed RCA #112, who indicated that staff were oriented to proper assembly of the specific cover for the mobility aid device. The RCA stated that resident #002 used a specific brand of mobility aid device at the time of the incident. The RCA indicated that when they reviewed the incident, they identified that the resident's specific mobility aid device cover was missing and that the specific device was positioned upside down on the mobility aid and not applied properly, as per the manufacturer's directions.

Inspector #638 reviewed the "Assembly, Installation and Operating Instructions" for the specific mobility aid device. The instructions identified that the specific mobility aid device was supposed to be installed directly to the specific inner portion of the mobility aid device and then both pieces were to be placed into the specific mobility aid cover.

In an interview with Inspector #638, the acting Administrator indicated that resident #002's mobility aid did not have the proper cover applied. The acting Administrator indicated that leaving off the specific cover would be considered altering the device, posed a safety risk to the resident and that the mobility aid device was not implemented onto the mobility aid as per the manufacturer's instructions. [s. 23.]

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 to ensure that positioning aids used on resident #002 or any other resident, are used in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the suspicion of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

A CIS report was submitted to the Director on a specific date, which indicated that resident #001 was found lying on the floor four days prior at a specific time. The CIS report identified that the resident did not receive their specific scheduled care and sustained a fall. Please refer to WN #1 for details.

In an interview with Inspector #638, RPN #103 indicated that if they witnessed or suspected abuse or neglect they were required to immediately report to the RN in charge or management.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01" Last updated April 2017, indicated that the Administrator or Designate were to ensure that the reporting requirement to provincial/regulatory bodies had been completed as required.

In an interview with Inspector #638, the acting Administrator indicated that they became aware of the incident one day after the incident occurred, however, due to lack of information surrounding the incident, it was not clear that there was any form of neglect. Upon reviewing an interview held between the acting Administrator and RN #110 three days after the incident, where the RN alleged neglect as a result of this incident, the acting Administrator indicated that they should have reported the incident at that time but reported one day later (four days after the incident had occurred). [s. 24. (1)]

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Issued on this 9th day of April, 2019

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

Original report signed by the inspector.