Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 15, 2020	2020_829757_0002	019994-19, 020738-19, 021170-19, 024038-19, 024216-19	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

DAVID SCHAEFER (757), DEBBIE WARPULA (577)

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): January 6-10, 2020.

The following intakes were inspected during this Critical Incident System (CIS) inspection:
- Three intakes related to resident falls, which caused an injury to the resident for which the resident was taken to hospital, and which resulted in a significant change in the resident's health condition.
- Two intakes related to resident-to-resident responsive behaviours.

Follow-Up Inspection #2020_829757_0001 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Clinical Manager (CM), Unit Coordinators, Restorative Care Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Physiotherapy Assistant (PTA), Psychogeriatric Resource Consultants (PRCs), Health Care Aides (HCAs), Support Workers, and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, resident-to-resident interactions, and reviewed relevant resident health care records, internal investigation records, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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	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 O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

a) A Critical Incident System (CIS) report was received by the Director concerning resident #005, who had fallen and suffered a significant injury.

Inspector #577 conducted a record review of resident #005's progress notes and found that the resident also had two subsequent falls the same month.

A review of the home's policy, "Fall Prevention and Management Program, RC-15-01-01", last revised August 2019, indicated that if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record". As part of the post-fall management, staff were also required to have completed a post-fall assessment, as well as a post-fall huddle. The policy directed staff to assess the following at each shift for 72 hours post-fall: vital signs, pain, bruising, changes in functional status, changes in cognitive status, and changes in range of motion.

A review of the Clinical Monitoring Record indicated that staff were to have assessed the following every hour for four hours, then every eight hours for 72 hours:
- Neurovital signs (if head/brain injury suspected or the fall was unwitnessed);
- Vital signs;

- Assess for pain; and
- Monitor for changes in behaviour.

Inspector #577 reviewed the falls documentation for resident #005, and found the following inconsistencies:
- First fall – Witnessed fall; the Clinical Monitoring Record had not been implemented, there was no record of vital signs or a pain assessment completed, and the post-fall assessment indicated vital signs dated prior to the fall.
- Second fall – Unwitnessed fall; there was no record of neurovital signs, no completed post-fall assessment, only two completed pain assessments, and vitals signs had not been completed every hour for four hours.
- Third fall – Unwitnessed fall; vital signs and neurovitals were initiated on the Clinical Monitoring record following the fall; however, they were not completed every hour for four hours.

During an interview with the Restorative Care Coordinator, they reported that staff were required to document the following after a fall:
- Post-fall assessment; and
- Clinical Monitoring Record; initiated after a fall, and completed every hour for four hours, then every eight hours for 72 hours, with neurovital signs and a pain assessment to be completed following unwitnessed falls or a suspected head injury, or with a pain assessment following witnessed falls.
Together with Inspector #577, the Restorative Care Coordinator reviewed resident #005’s post-fall documentation, and confirmed the inconsistencies.

During an interview with the Director of Care (DOC), they reviewed resident #005’s post-fall documentation with Inspector #577. The DOC confirmed the inconsistencies with documentation and reported that staff did not implement the Falls program.

b) A CIS report was received by the Director related to resident #006 who had fallen, was found complaining of severe pain, and was subsequently transferred to the hospital for further assessment.

During a record review, Inspector #577 found that while the Clinical Monitoring Record had been implemented at the time of the fall, in order to monitor vital signs, the neurovital signs weren’t completed and the pain assessment was dated prior to the incident.

During an interview with the DOC, they confirmed that neurovital signs and a pain

assessment were not completed on the Clinical Monitoring Record, prior to resident #006's transfer to hospital. They confirmed that staff had not implemented the Falls program.

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 the home's interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee has failed to make a report in writing to the Director setting out the following with respect to an incident reported under subsection (1), (3) or (3.1): Actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.

A CIS report was received by the Director related to resident #005, who had fallen and suffered a significant injury.

Inspector #577 reviewed the CIS report and found that the report indicated, under the heading of outcome/current status of the individual who was involved in the occurrence, “family member aware [incident intervention]”. Inspector #577 found that there were no amendments made to include information regarding the resident's outcome or current status.

A review of the home’s policy, “Mandatory and Critical Incident Reporting - RC-09-01-06", last revised April 2017, indicated that documentation required in the CIS report would include the outcome or current status of the individual who was involved in the incident.

During an interview with the DOC, they confirmed that documentation on the CIS report had not been amended to have included information related to resident #005’s outcome or current status.

Issued on this 16th day of January, 2020

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

Original report signed by the inspector.