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
Aug 13, 2020	2020_829757_0018	011378-20	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)

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 27-31, 2020.

The following intake was inspected was inspected during this Critical Incident System inspection:
-One intake related to the fall of a resident which resulted in an injury and subsequent transfer to hospital.

This inspection was conducted concurrently with Complaint inspection #2020_829757_0017.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Manager, Registered Nurses (RNs), Registered Practical Nurse (RPN), and Health Care Aides (HCAs).

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.

- **1 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #001.

A Critical Incident System (CIS) report was received by the Director, related to a fall of resident #001.

The home's policy "Falls Prevention and Management Program - RC-15-01-01", last updated December 2019, indicated that when a resident had fallen, nursing staff were to implement the Post Fall Clinical Pathway. The Inspector reviewed appendix 5 of the policy, titled "Post Fall Clinical Pathway", which indicated that following a focused assessment by the first registered staff person on scene, a clinical decision would be made by the registered staff to either 1) decide not to move the resident; 2) decide to move the resident using a mechanical lift; or 3) the resident gets up independently.

During an interview with Registered Practical Nurse (RPN) #105, the first registered staff member to respond to the incident, they stated that following their initial assessment of the resident, the RPN and a Health Care Aide (HCA) first sat the resident up, before they stood on either side of the resident and physically stood them up from the ground. The RPN stated that they were not sure if the home's falls prevention and management program indicated that when residents were assessed to be safe to be transferred from the ground following a fall, that a mechanical lift should be used.

Inspector #757 conducted an interview with the home's Administrator, who indicated that the RPN and HCA had not followed the home's falls prevention and management program. They stated that the method in which resident #001 was lifted utilized poor body mechanics, and had potential to injury both the resident as well as the staff members. [s. 36.]

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

Issued on this 14th day of August, 2020

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

Original report signed by the inspector.