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
Mar 10, 2021	2021_740621_0004	015071-20, 015824-20, 017803-20, 018591-20, 020086-20	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

JULIE KUORIKOSKI (621), 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): February 22 - 26, 2021, and March 1 - 3, 2021.

The following intakes were inspected during this Critical Incident System (CIS) Inspection:
- Two intakes, with associated CIS reports, related to responsive behaviour management;
- Two intakes, with associated CIS reports, related to falls management; and
- One intake, with associated CIS report, related to alleged staff-to-resident abuse.

Follow Up Inspection #2021_740621_0003 was conducted concurrently with this CIS Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a Registered Nurse (RN), Registered Practical Nurses (RPNs), Healthcare Aides (HCAs), Housekeeping Aides (HAs), a Laundry Aide (LA) and residents.

The Inspector(s) also conducted daily tours of the resident care areas; observed the provision of care and services to residents; and reviewed the home's supporting documentation and relevant resident health care records.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

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 care set out in the plan of care, with respect to falls management for a resident, was provided as specified in their plan.

A resident had an un-witnessed fall, which resulted in injury. The resident's care plan at the time of the incident indicated that the resident was to have a certain number of safety devices positioned in a certain location, when the resident was engaged in a particular activity. At the time of the incident, the identified safety devices were not positioned as required. The staff member assigned to the resident's care at the time of the incident, indicated that they were not familiar with the resident's falls care plan and required interventions at the time.

Sources: Resident's electronic progress notes, care plan, and post-fall assessment; A specific Critical Incident System (CIS) report; Staffing documentation; and interviews with one particular staff member, the Administrator, and other relevant staff members. [s. 6. (7)]

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 the care set out in the plan of care for the identified resident, is provided as specified in their plan, to be implemented voluntarily.

WN #2: 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 staff complied with the home's zero tolerance of abuse and neglect of residents policy, with regard to physical abuse of an identified resident.

Ontario Regulation (O. Reg.) 79/10 defines physical abuse as the use of physical force by anyone other than a resident.

A CIS report submitted to the Director, identified that a resident was physically abused by a staff member. The report identified that the staff member was observed by another staff member to apply particular physical actions and force to the resident, after the resident had displayed responsive behaviours.

During an interview with the staff member, they confirmed to Inspector #621 that what they had done was abuse. During an interview with the DOC, they confirmed that the identified staff member was found to have physically abused the resident, and consequently, the home's Zero Tolerance of Abuse and Neglect policy had not been complied with.

Sources: A specific CIS report; The home's most current Abuse and Neglect Zero Tolerance Policy; The home's critical incident investigation file; Employment and training records for a specific staff member; and interviews with the identified staff member, the DOC and other relevant staff. [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 a written policy that is in place to promote zero tolerance of abuse and neglect of a certain resident, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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 for a certain resident demonstrating responsive behaviours, a particular strategy was implemented to respond to the behaviours.

A CIS report was submitted to the Director for alleged physical abuse of a resident by a staff member. The CIS report identified that the resident had been displaying responsive behaviors prior to the incident.

During an interview with a staff member, they reported that the resident had responsive behaviours and required a specific strategy implemented for a certain interval of time. The staff member indicated that at the time of the incident, the strategy was not in place. A review of the resident's care plan found no record that the strategy was in place at the time of the incident. A subsequent interview with the DOC confirmed that the strategy had been established by the home, but was not implemented to respond to the resident's behaviours at that time.

Sources: A particular CIS report; Home's Call In Sheet; The resident's care plan; and interviews with a specific staff member, the DOC and other relevant staff. [s. 53. (4) (b)]

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 for the specific resident, demonstrating responsive behaviours, that a particular strategy is implemented to respond to the behaviours, to be implemented voluntarily.

Issued on this 11th day of March, 2021

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

Original report signed by the inspector.