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
Oct 6, 2021	2021_829757_0020	011057-21	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): September 27-29 & October 1, 2021.

The following intake was inspected during this Complaint inspection:
-a complaint related to resident rights regarding access to the home for visitors; and resident care concerns regarding continence care and snack service.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), a housekeeper, 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, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Snack Observation

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care for two residents was documented.

A) A resident's care plan indicated that staff were required to provide a number of scheduled interventions. The resident's point-of-care (POC) documentation did not include documentation related to the multiple scheduled interventions. The resident's progress notes included minimal notes related to the scheduled care, and did not document that these interventions were completed at each of the required intervals indicated in the resident's care plan.

B) Another resident's care plan indicated that staff were required to provide a scheduled intervention. The resident's POC documentation and progress notes did not include any documentation related to this intervention.

A Registered Practical Nurse (RPN) indicated that residents who required scheduled interventions would have the provision of those interventions documented in POC by Health Care Aides (HCAs) or in progress notes by RPNs. The Administrator indicated that HCA staff would not be able to properly track that the intervention had been completed as required without documenting the provision of scheduled interventions at the required intervals. The Director of Care (DOC) stated that it was their expectation that scheduled interventions would be documented in POC.

Sources: Two resident's care plans, progress notes, and POC documentation; and interviews with the DOC, Administrator, an RPN, and other relevant staff members. [s. 6. (9) 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 the provision of care set out in residents' plans of care is documented, to be implemented voluntarily.

Issued on this 7th day of October, 2021

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

Original report signed by the inspector.