Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: June 26, 2023	
Inspection Number: 2023-1527-0002	
Inspection Type: Critical Incident System	
Licensee: Riverside Health Care Facilities Inc.	
Long Term Care Home and City: Rainycrest, Fort Frances	
Lead Inspector Ryan Goodmurphy (638)	**Inspector Digital Signature**
Additional Inspector(s) Lisa Moore (613)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 6 and 7, 2023.

The following intake(s) were inspected:
- One intake related to a fall resulting in a change in status;
- One intake related to abuse of a resident; and
- One intake related to improper care of a resident.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that the improper treatment of a resident that resulted in a risk of harm to the resident was immediately reported to the Director.

Rationale and Summary:
In response to the resident's behaviours, a staff member applied a prohibited device to the resident, with another staff member's assistance. A third staff member reported the incident to management, however, the incident was only reported to the Director via the after hours line one day after the incident had occurred.

The Administrator identified that registered staff should have reported the incident through the after hours line at the time of the incident. There was no risk to the resident when the home failed to immediately report the incident to the Director.

Sources: Email correspondence; home policies; interviews with the Administrator, Director of Care and other staff. [638]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that two PSWs used safe transferring techniques when they assisted a resident.

Rationale and Summary:
Two PSWs were transferring the resident when they fell. The PSWs used an incorrect piece of equipment for the transfer, which was not in line with the resident's plan of care.

Staff failed to ensure safe transferring techniques, which resulted in moderate harm to the resident.

Sources: The resident's health care records including their Minimum Data Set, care plan and progress notes; home policies; the home's investigation files; interviews with the Administrator and other staff.

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[613]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

The licensee has failed to ensure that a resident had written strategies developed, which included techniques and interventions, to prevent, minimize or respond to their specific responsive behaviours.

Rationale and Summary:
A PSW identified that on a specific date, staff were in shock that the resident was demonstrating specific responsive behaviours and it was the first time the resident was like that for them. The resident's progress notes outlined a history of the specific responsive behaviours. Their plan of care did not identify the type of behaviour known nor techniques or interventions to prevent, minimize or respond to the specific behaviour.

The Administrator identified that the resident's care plan should have outlined specific types of behaviours which included triggers and interventions when they had been identified. There was moderate risk as staff may have been unaware of the potential behaviour and how to respond.

Sources: The resident's health care records; progress notes; care plan; home policy; email correspondence; interviews with the Administrator, Director of Care and other staff. [638]

WRITTEN NOTIFICATION: Prohibited Devices that Limit Movement

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 121. 7.

The licensee has failed to ensure that specific devices were not used as a restraining device, at any time.

Rationale and Summary:
In response to a resident's responsive behaviours, a staff member applied a prohibited device to the resident, with another staff member's assistance. The Administrator identified that staff were not able to use the device that had been applied regardless of intent.

There was moderate risk to the resident when staff implemented a prohibited device which limited mobility and was not able to be immediately released by staff.

Sources: The home's investigation files; email correspondence; home policies; interviews with the Administrator, Director of Care and other staff. [638]