Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of inspection/Genre d'inspection
Jul 10, 11, 12, 13, 19, Sep 5, 6, 2012	2012_104196_0018	Critical Incident

Licensee/Titulaire de permis

RIVERSIDE HEATH 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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents

During the course of the inspection, the inspector(s) conducted a tour of all resident care areas, observed the provision of care and services to various residents, reviewed the health care records of several residents, reviewed Critical Incident #C608-000001-12, #C608-000009-11, #C608-000012-12 that were submitted to the Ministry of Health and Long-Term Care (MOHLTC)

MOHLTC Log#s inspected: S-000034-12,S-001307-11,S-000667-12

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The progress notes dated May 22, 2011 for resident #002 were reviewed by the inspector and included two separate entries indicating the resident made comments to staff members regarding self harm. Resident #002 subsequently did commit an act of self harm which resulted in injury and transfer to hospital for treatment. The care plan that was in place at the time of the incident with a focus of "cognitive loss/dementia" and "mood state" dated February 14, 2011, did not reflect this responsive behaviour and did not contain reference to the need for heightened monitoring because of the threat of self harm comments made by the resident. The resident's plan of care was not revised to reflect this change in responsive behaviour that had been documented in the progress notes.

The licensee failed to 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 (b) the resident's care needs change or care set out in the plan is no longer necessary. [LTCHA 2007,S.O.2007,s.6.(10)(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 that will ensure that all residents are reassessed and their plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The progress notes dated May 22, 2011 for resident #002 were reviewed by the inspector and included two separate entries indicating the resident made comments to staff members regarding self harm. Resident #002 had access to sharp implements in their toiletry bag and subsequently did commit an act of self harm which resulted in injury and was transferred to hospital for treatment. The care plan that was in place at the time of the incident with a focus of "cognitive loss/dementia" and "mood state" dated February 14, 2011, did not reflect this responsive behaviour and there was no reference to the need for heightened monitoring because of the threat of self harm statements made by the resident. The resident was at risk of responsive behaviours that could cause harm to themselves and the home did not implement strategies to prevent such an incident from happening.

The licensee failed to ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. [O. Reg. 79/10, s. 55.(a).]

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 that will ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The inspector reviewed Critical Incident #C608-000001-12 that had been submitted to the Ministry of Health and Long -Term Care (MOHLTC) in January 2012 for an incident involving resident #001. The resident had consumed disinfectant cleanser which resulted in transfer to hospital. It was unknown how the resident came into possession of the cleanser.
Inspector conducted an initial tour of the home on July 10, 2012 at 0910hrs and observed the door to the soiled utility room, # W14, open and accessible to residents. The door had a combination lock but the door was propped open approximately 5 cm. The unlocked cupboard under the sink contained a cleanser titled "TOTAL" universal cleaner/polisher which had a toxic label and also there was a spray container of "Spray Glo" furniture polish which stated on the container "harmful/fatal if swallowed". The door to the utility room was left open and it contained hazardous substances which were accessible to residents.

The licensee failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. [O. Reg. 79/10, s. 91.]

Issued on this 7th day of September, 2012

Signature of Inspector(s)/Signature de l'Inspecteur ou des inspecteurs

L. Lehmann #196.