Ontario

Ministry of Health and Long-Term Care

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

Ministére 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, 17, Sep 7, 20, 2012	2012_104196_0021	Complaint

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 Complaint 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), Dietary staff, Residents and family members and substitute decision-makers.

During the course of the inspection, the inspector(s) conducted a tour of all resident home areas, observed the provision of care and services to residents, reviewed the health care records of various residents, reviewed the home's policies and procedures relating to complaint process.

The Ministry of Health and Long-Term Care Log's reviewed: S-000169-12,S-001537-11,S-000421-12,S-00839-12.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Dignity, Choice and Privacy

Nutrition and Hydration

Reporting and Complaints

Skin and Wound Care

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Findings of Non-Compliance were found during this inspection.

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	Legendé 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. According to information received by the Ministry of Health and Long-Term Care (MOHLTC), resident #002 was moved to a new dining room within the home and the substitute decision-maker (SDM) was not informed of this change nor given the reason for this change. An interview was conducted with staff member #100 on July 12, 2012 and it was identified that changes to the seating plan can occur frequently depending on resident needs and that staff would try to inform the SDM of any changes, out of courtesy, but they are not always informed. The home did not provide resident #002's SDM the opportunity to fully participate in the plan of care, specifically the home did not notify the SDM of the change to a new dining room and the reason for the change.
2. The substitute decision-maker (SDM) of resident #002 had observed a wound on the leg of their family member and according to the SDM, the home had not informed them of this wound. The inspector reviewed the resident's progress notes and could not identify any reference to notifying the SDM of the wound, although there were two separate entries regarding the assessment and treatment of the wound. The home did not provide an opportunity for the SDM to participate fully in the resident's plan of care, specifically the home had not notified the SDM of the resident's wound.

The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007,S.O.2007, c. 8, s. 6 (5).]

Issued on this 20th day of September, 2012

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

Lauren Stark #196.