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, Aug 21, Sep 7, 20, 21, 2012	2012_104196_0020	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), Residents, family members

During the course of the inspection, the inspector(s) conducted a tour of 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 complaints and transferring of residents.

The following Ministry of Health and Long-Term Care Log's were reviewed: S-000317-12,S-000512-12.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Personal Support Services

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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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. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. An interview was conducted on July 13, 2012 with staff member #101 and it was identified that there was no formal process or written procedures to follow regarding complaints. An interview was conducted with staff member #102 and it was reported that the complaint procedure was currently being drafted.

The licensee failed to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. [LTCHA 2007,S.O.2007, c. 8, s. 21.]

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 ensures that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.

3. A missing or unaccounted for controlled substance.

4. An injury in respect of which a person is taken to hospital.

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The progress notes for resident #001 were reviewed by the inspector. In the month of April 2012, it was recorded in the notes that this resident was complaining of "alot of pain in their left arm" and the staff heard "a creak from resident on transferring with the ceiling lift". The physician was notified and the resident was sent to hospital two days later for an xray. An interview was conducted on July 12, 2012 with staff member #100 and it was identified that this resident had injured their arm while being transferred by staff members. Staff member #100 was not aware if the incident of injury and transfer to hospital was reported to the Director. Inspector reviewed the Ministry of Health and Long-Term Care (MOHLTC) reporting system and there was no record of this report. The report in writing required under subsection (4) for an injury and transfer to hospital, was not submitted to the Director.

The licensee failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital. [O.Reg. 79/10,s.107.(3)4.]

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 ensures that the Director is informed of an incident in the home no later than one business day after the occurrence of the incident, followed by the report for an injury in respect of which a person is taken to hospital, to be implemented voluntarily.

Issued on this 21st day of September, 2012

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

Tamara Senko #196.