Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2012_104196_0045
Log No. / Registre no:	S-001275-12
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 19, 2013
Licensee / Titulaire de permis :	RIVERSIDE HEALTH CARE FACILITIES, INC. 110 VICTORIA AVENUE, FORT FRANCES, ON, P9A-2B7
LTC Home / Foyer de SLD :	RAINYCREST 550 OSBORNE STREET, FORT FRANCES, ON, P9A-3T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	EDITH BODNAR

To RIVERSIDE HEALTH CARE FACILITIES, INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

Grounds / Motifs :

1. In October 2012, resident #002 was admitted to the special care unit of the home. The behavioural assessment that had been provided to the home prior to the resident's admission, had identified concerns with wandering, agitated behaviour, verbally aggressive/angry behaviour and had noted two previous assaults on others. The progress notes from the date of admission through to the date of inspection were reviewed by the inspector. According to the progress notes for resident #002, the resident wandered into other resident rooms and had physically assaulted the occupants. On the following day, there were four separate notations outlining the resident's behaviours. The progress notes on another day, outlined an incident in which resident #002 had yelled at another resident when they had wandered into their room and had threatened to hit several staff members when they had attempted to redirect. Resident #002 approached another resident and grabbed their hat and pulled their necklace off and later that same day was noted to have other behaviours such as yelling and swearing at other residents, wandering into other resident's rooms and had attempted to strike out at multiple staff members. A Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in November 2012 outlining an incident in which resident #002 assaulted resident #001 resulting in bruising to their arm.
Despite having a history of responsive behaviours towards others, resident #002 was able to wander into other resident rooms, display aggressive behaviour and verbally and physically assault residents in the home as noted in the progress notes. The licensee did not effectively minimize the risk of altercations and potentially harmful interactions between resident #002 and other residents in the home.

The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions.
(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 03, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of March, 2013

Signature of Inspector / Signature de l'inspecteur : Lauren Tenhunen #196.

Name of Inspector / Nom de l'inspecteur : Lauren Tenhunen

Service Area Office / Bureau régional de services : Sudbury Service Area Office

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 19, 2013	2012_104196_0045	S-001275-12	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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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 sous la Loi de 2007 sur les foyers de soins de longue durée

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 6, 7, 8 2012

Ministry of Health and Long-Term Care (MOHLTC) log #'s: S-001275-12,S-001281 -12,S-001282-12

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

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed the provision of care and services to residents, reviewed the health care records of various residents, reviewed the home's policy and procedures for responsive behaviours

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

Safe and Secure Home

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

In October 2012, resident #002 was admitted to the special care unit of the home. The behavioural assessment that had been provided to the home prior to the resident's admission, had identified concerns with wandering, agitated behaviour, verbally aggressive/angry behaviour and had noted two previous assaults on others. The progress notes from the date of admission through to the date of inspection were reviewed by the inspector. According to the progress notes for resident #002, the resident wandered into other resident rooms and had physically assaulted the occupants. On the following day, there were four separate notations outlining the resident's behaviours. The progress notes on another day, outlined an incident in which resident #002 had yelled at another resident when they had wandered into their room and had threatened to hit several staff members when they had attempted to redirect. Resident #002 approached another resident and grabbed their hat and pulled their necklace off and later that same day was noted to have other behaviours such as yelling and swearing at other residents, wandering into other resident's rooms and had attempted to strike out at multiple staff members. A Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in November 2012 outlining an incident in which resident #002 assaulted resident #001 resulting in bruising to their arm.
Despite having a history of responsive behaviours towards others, resident #002 was able to wander into other resident rooms, display aggressive behaviour and verbally and physically assault residents in the home as noted in the progress notes. The licensee did not effectively minimize the risk of altercations and potentially harmful interactions between resident #002 and other residents in the home.

The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Staff member #103 provided a copy of the home's responsive behaviour program and policy documents to the inspector for review. The procedure to develop a comprehensive plan of care relating to responsive behaviours was not followed. Appendix 2 is titled "Strategies for Responsive Behaviours" and includes the foci of agitation, wandering, sexual behaviours, sundowning and then includes strategies that can be adapted for the individual resident in order to to address these issues. Resident #002's most current care plan was reviewed and did not contain the strategies as listed in Appendix 2 for the resident's wandering and sundowning responsive behaviours. The home did not implement or comply with their own policies for residents exhibiting responsive behaviours.

Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with. [s. 8. (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 that ensures the licensee's responsive behaviour policy and procedure is implemented and complied with for resident #002 who is exhibiting responsive behaviours, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. A Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in November 2012, outlining an incident in the special care unit, in which resident #002 assaulted resident #001 resulting in bruising to their arm. This incident was documented in both resident #002's progress notes and on the submitted report as occurring at 1855hrs on a particular day in November 2012. A similar incident had occurred a few days prior when resident #002 struck out at resident #001. In addition, it was identified that at the time of this incident with injury, there was only two staff on the unit.
2. On November 7, 2012, an interview was conducted with staff member #100 and it was reported to the inspector that on the evening shift there is one RPN and two PSW's on the special care unit with an activity aide working till 1730hrs. After 1730hrs, the staffing is reduced to two staff because of staff supper and breaks. It was also reported that approximately half of the residents in the unit require two person assist with care.
3. An interview was conducted with staff member #101 on November 6, 2012 and it was reported that over the course of the evening shift, there are times when two staff are required to provide care to a resident ie. toileting, bathing, assisting with HS care and then, because of staff breaks, there is no staff left to supervise and monitor the remaining residents. Staff member #101 also told the inspector that there is an increase in behaviours after 1430hrs in the afternoon, and between the hours of 1800 to 2200hrs.
4. On Nov. 6, 2012, from 1710hrs through to 1845hrs, the inspector observed the staffing coverage in the special care unit to determine the supervision and monitoring of residents. The activity staff member was present in the unit up until 1730hrs, then after this time, there was 1 RPN and 2 PSW's. At 1800hrs, PSW #1 went on a supper break and PSW#2 was observed during this time period to redirect residents in the corridor and in the common TV room and the RPN was observed to administer medications to a couple of residents and to also assist with the redirection of residents. At 1830hrs, both the RPN and PSW#2 were observed pushing a lift apparatus down the corridor as it was reported that a resident had had a fall in their washroom. The inspector observed several residents in the common TV room and in the corridors wandering, without staff supervision or monitoring for a period of four minutes, prior to the RPN returning to the nursing station.
5. An interview was conducted with staff member #103 on Nov. 7, 2012 regarding the staffing plan for the special care unit. It was reported that the special care unit requires "team work, and the staff have to work together, because the resident needs and behaviours often require two staff for a lot of the personal care." It was also

reported that most residents that are admitted to the special care unit, have behaviours and are exit seeking.
6. An interview was conducted on November 6, 2012 with staff member #101 and it was reported that resident #002 was "territorial and wanders in and out of other resident rooms". Inspector conducted an interview with staff member #102 on Nov. 6, 2012 and it was identified that this resident's behaviour changes and they become aggressive and agitated as a result of sundowning on the evening shift, and they also wander into other resident's rooms and becomes territorial. Despite having a history of responsive behaviours towards others, resident #002 was able to wander into other resident rooms, display aggressive behaviour and verbally and physically assault residents in the home as noted in the progress notes.
The staffing mix in the special care unit does not meet the care and safety needs of resident #002 and the remaining residents in the unit.

The licensee failed to ensure that the staffing plan must, (a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; [s. 31. (3)]

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 the staffing plan will provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. An interview was conducted on November 6, 2012 with staff member #101 and it was reported that resident #002 was "territorial and wanders in and out of other resident rooms". Inspector conducted an interview with staff member #102 on Nov. 6, 2012 and it was identified that this resident's behaviour changes and they become aggressive and agitated as a result of sundowning on the evening shift, and they also wander into other resident's rooms and becomes territorial. Resident #002's care plan was reviewed for information regarding wandering concerns and sundowning. The care plan did identify wandering and referred to sundowning as responsive behaviours for this resident but did not include strategies that would address these behaviours. Staff members reported that resident #002 had been demonstrating responsive behaviours since admission, specifically wandering and sundowning. Strategies were not developed and implemented to respond to these behaviours.

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours, where possible; [s. 53. (4) (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, for resident #002 and each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

Issued on this 3rd day of April, 2013

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

Lauren Lenhuren #196.