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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 27, 2013	2013_211106_0035	S-000410-13	Critical Incident System

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 16, 17, 2013

The following log was reviewed as part of this complaint inspection: Log# S-000410-13

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

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records

The following Inspection Protocols were used during this inspection:
Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. A Critical Incident System (CIS) Report, submitted to the Ministry of Health and Long-Term Care indicated, that resident #001 pushed resident #002 to the floor, resident #002 sustained an injury and was transferred to hospital.

Progress notes for resident #001 were reviewed by the inspector, no documentation was found that indicated resident #001 had been physically abusive with co-residents other than the above incident. On October 17, 2013, inspector interviewed a PSW and a RPN who reported that they have witnessed resident #001 yell at co-residents and "slam" objects, but have not witnessed resident #001 be physically abusive towards co-residents.

The plan of care for resident #001 was reviewed, there was no clear indication in the plan of care, that the resident could become physically and verbally abusive towards co-residents or that the resident had seriously injured a co-resident in the past.

The plan of care did not provide clear directions to staff and others who provide direct care to resident #001 regarding how to manage the resident when they become physically and verbally abusive to co-residents. [s. 6. (1) (c)]

2. A Critical Incident System (CIS) Report, submitted to the Ministry of Health and Long-Term Care, indicated that resident #002 sustained an injury. On October 16 and 17, 2013 inspector observed resident #002 to be non-ambulatory. On October 17, 2013 inspector asked a PSW if resident #002 was currently able to ambulate independently and they replied no.

The plan of care for resident #002 was reviewed and in the section titled "ADL Assistance" the following interventions were found in regards to locomotion:
-"Independent walking in room"
-"Independent walking in corridor"
-"Independent on unit"

The licensee failed to ensure that the resident was reassessed and the 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. [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 to ensure that there is a written plan of care for resident #001 that sets out clear directions to staff and others who provide direct care to the resident, specifically in regard to managing abusive behaviours and that resident #002 is reassessed and the 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 inspector reviewed the Critical Incident System (CIS) reports that the home had submitted to the MOHLTC from June 1, 2013 to November 26, 2013. Eight of the reports that were submitted were incidents involving resident to resident altercations and one report was regarding a resident to staff altercation.

On October 17, 2013, inspector requested that the DOC provide the inspector with the procedures and interventions which have been 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. The DOC was unable to provide the requested material.

The licensee failed to 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. [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 to 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. On October 16, 2013, during the initial tour of the home, the inspector observed 4 residents in the special care unit dining room. The residents were unsupervised and had coffee cups in front of them. Resident #003 had spilled a large amount of coffee on the front of their shirt.

The Administrator approached the inspector outside of the dining room and the inspector reported what they had found. The Administrator told the inspector, that the residents should have been monitored and was observed telling staff members, who were decorating in the court yard beside the dining room, that the residents in the dining needed to be monitored.

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, monitoring of all residents during meals. [s. 73. (1) 4.]

Issued on this 28th day of November, 2013

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