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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2017	2017_700536_0016	022820-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE THOMAS HEALTH CARE CORPORATION
490 Highway #8 STONEY CREEK ON L8G 1G6

Long-Term Care Home/Foyer de soins de longue durée

PINE VILLA NURSING HOME
490 HIGHWAY #8 STONEY CREEK ON L8G 1G6

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

CATHIE ROBITAILLE (536), LISA BOS (683)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 4, 5 ,6, 10, 11 and 12, 2017.

The following inspections were completed concurrently with the Resident Quality Inspection (RQI).

Critical Incident System Reports:

Intake #003731-17: pertaining to: insufficient staffing

Inquiry:

Intake #032174-16 pertaining to: admission to the home

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW's), registered staff, dietary staff, Dietitian, Director of Environmental Services, business office staff and Administrator/Director of Care.

During the course of the inspection, the inspector(s) toured the home, observed meal services, observed the provision of care and services provided on the home area, interviewed staff, residents and families, and reviewed relevant documents including, health care records, training records, staffing schedules, meeting minutes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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:

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. The licensee has failed to ensure that resident #001, #004 and #007 were 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 changed, or when care set out in the plan of care was no longer necessary.

A) On an identified date, resident #001's plan of care which the home refers to as the care plan, identified that they had an identified intervention as a fall prevention strategy. During interview, registered staff #100 and Personal Care Workers (PSW's) #104 and #105 acknowledged that resident #001 was not using the identified intervention as a fall prevention strategy at the time of the inspection.

B) On an identified date, resident #004's plan of care which the home refers to as the care plan, specified that they had an identified intervention as a fall prevention strategy. Registered staff #100 and PSW's #110 and #103 acknowledged that resident #004 was not using the identified intervention as a fall prevention strategy at the time of the inspection.

C) On October 10, 2017, resident #007's plan of care which the home refers to as the care plan, specified that they they had an identified intervention as a fall prevention strategy. Registered staff #100 and PSW's #110 and #103 acknowledged that resident #007 was not using the identified intervention as a fall prevention strategy at the time of the inspection.

The home failed to ensure that resident #001's, #004's and #007's plan of care was reviewed and revised when the resident's care needs changed or when care set out in the plan of care was 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 and ensuring that the plan of care is reviewed and revised when resident's care needs change or when care set out in the plan of care was no longer necessary, to be implemented voluntarily.

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. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with s. 11. (1), that required a long term care home to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. LTCHA, 2007, S.O. 2007, C. 8, s.11(1)

A) The home's policy number: RC-05-02-10, "Activities of Daily Living Nutrition - The Dining Experience Routine," last reviewed and revised: March 8, 2008, identified that nursing staff were to record resident food and fluid intake at the end of meal service on the designated intake form.

i. Resident #004's clinical record identified that they were on an specified diet and

texture. Their care plan directed staff to document the amount of meal taken. A review of the food and fluid intake records for specified dates, identified that the resident's food and fluid intake at supper and bedtime (HS) snack were not documented on identified dates. Resident #004's food and fluid intake at lunch and afternoon (PM) snack, were also not documented on other specified dates.

Resident #004's food and fluid intake records were reviewed for identified dates. Staff were to document Full (F), ¾, ½, 1/4 , 0, Refused (R), Sleeping (S), Hospital (H) or Leave of absence (L.O.A) for food intake at all meals and snacks. On October 11, 2017, PSWs #103 and #116 reviewed the daily food and fluid intake record for resident #004, upon request, and acknowledged that as per their current documentation practices on the food and fluid flow sheets, it did not appear as if the resident had anything to eat on the majority of the mornings during identified dates. Interview with the Administrator on October 11, 2017, they acknowledged that the current documentation practices of the PSWs on the food and fluid intake sheet for resident #004 did not accurately reflect their nutrition intake. They identified changes that could be made to the form for residents on specified programs. Interview with RN #108 on October 12, 2017, acknowledged that the food and fluid intake for residents on these programs should be documented on the food and fluid intake record in order to identify how much they ate, or if they refused a meal.

ii. Resident #005's clinical record identified that they were on a specified diet and texture. Their care plan identified that they were at a specified nutrition risk. Their care plan directed staff to "document the amount of consumed meals and snacks on provided documentations as per home policy." A review of the food and fluid intake records for specified dates, identified that the resident's food and fluid intake at supper and HS snack were not documented. Resident #005's food and fluid intake at lunch and PM snack were also not documented on other specified dates.

iii. Resident #007's clinical record identified that they were on a identified diet with texture, Their care plan identified that they were at a specified nutrition risk. Their care plan directed staff to "document the amount of meal taken: F=full, P=partial, R=refused, Fl=fluids only." A review of the food and fluid intake records for a specified date, identified that the resident's food and fluid intake at supper and HS snack were not documented. Resident #005's food and fluid intake at lunch and PM snack were also not documented on other specified dates.

Interview with the Registered Dietitian (RD) on October 11, 2017, identified that they used the food and fluid intake records to complete their nutritional assessment for

residents, and that it was difficult to complete their assessments with missing data. The RD identified that on September 30, 2017, they spoke with a registered staff member and asked for them to encourage the PSWs to complete their documentation. They acknowledged that the flow sheets were not fully completed for resident #004, #005 and #007.

Interview with the Administrator/Director of Care on October 11, 2017, acknowledged that it was their expectation that the food and fluid flow sheets were completed for all residents at every meal. After discussion with the staff, they identified that the staff forgot to document the resident's food and fluid intake on the identified dates and confirmed that the dining experience routine policy was not complied with.

The home did not ensure that the staff followed their Dining Experience Routine policy. [s. 8. (1) (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 and ensuring that plan, policy, protocol, procedure, strategy or system was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

On specified dates, resident #004 was observed using a specified device. The resident's clinical record did not identify the device as either a restraint or a personal assistive services device (PASD), and did not identify a physician's order or consent for the device. Interview with the Administrator on October 12, 2017, confirmed that there was no assessment, physicians order or consent for the use of the device. The home did not ensure that resident #004 was not restrained by the use of a physical device, other than in accordance with section 31 of the Act. [s. 30. (1) 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 and ensuring that no resident of the home was restrained by use of a physical device, other than in accordance with section 31 or under common law duty described in section 36, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

i) A change of 5 per cent of body weight, or more, over one month.

Resident #007's clinical record identified that they were on a specified diet and texture and were at an identified nutrition risk.

The resident's weight had remained stable since their admission to the home however, months later their next documented weight had changed. This change in body weight represented a weight loss of an identified amount over one month. Review of the progress notes identified that the Registered Dietitian (RD) completed an assessment on a specified date which identified that the resident had experienced weight loss; however, did not identify any interventions offered or tried to address the weight loss. A progress note from a specified date, identified that the resident had "variable [weight] with no changes in intake pattern, query scale accuracy, resident seen at meal eating well, no reported decreased oral intake."

On October 12, 2017, the Registered Dietitian (RD) identified that there was a referral for the resident's weight loss in an identified month, however it had "escaped" them. They also identified that they may have offered the resident a nutritional supplement in an identified month, but acknowledged that they did not document it. The RD acknowledged that they did not take action to address the resident's weight loss in an identified month, as they questioned the accuracy of the scale, and that the resident's weight had remained stable after that date. The home did not ensure that actions were taken and outcomes were evaluated for resident #007 when they experienced a change of body weight over one month. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 and ensuring that weigh changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a resident was being restrained by a physical device under section 31 of the Act, that the resident was released from the physical device and repositioned at least once every two hours.

Review of the clinical record for resident #002 identified that they required an identified physical device when up in their wheelchair. Resident #002 was observed on specified dates and times for the release of the identified physical device in place. On both occasions, the resident was repositioned by PSW staff; however, there was no further intervention to release the device at least every two hours. Interview with PSWs #104 and #105 identified that it was the expectation that residents with physical devices in place had the device released and were repositioned every two hours and documented on the restraint flow sheets.

During interview with RN #108 on October 12, 2017, they acknowledged that it was the home's expectation that resident #002's physical device should have been released at least every two hours. [r.110 (2) 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 and ensuring that where a resident was being restrained by a physical device under section 31 of the Act, that the resident was released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of falls prevention and management in accordance with O. Reg. 79/10, s. 221(1)1, in relation to the following: LTCHA, 2007, S.O. 2007, C. 8, s. [76(7)6]

During interview with the Administrator/Director of Care they revealed that the homes expectation is that 100 percent of direct care staff are to complete fall prevention training in Surge Learning. The Administrator/Director of Care acknowledged that only a 79 percent of staff who provided direct care to the residents received as a condition of continuing to have contact with residents, annual retraining in the area of falls prevention in 2016, and that not all direct care staff received the required annual retraining. [s. 221. (1) 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 and ensuring that all staff who provide direct care to the residents received as a condition to continuing to have contact with residents annual retraining in the area of falls prevention and management, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that each bedroom, occupied by more than one resident had sufficient privacy curtains to provide privacy.

On specified dates, it was observed that residents #002, #004 and #007 were in shared rooms which had privacy curtains that did not provide sufficient privacy. The curtains were fastened at one end to the ceiling tracts. When the curtains were extended, they did not provide sufficient privacy at the foot of the beds. The curtain on the tracking between resident #002's bed and their roommate's bed also allowed for a gap at the head of the bed.

On October 5, 2017, the Administrator observed the privacy curtains for residents #002, #004 and #007 with the Director of Environmental Services, and confirmed that their bedrooms did not have sufficient curtains to provide privacy. [s. 13.]

WN #8: 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. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that they kept a written record related to each evaluation under (3) (e) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes that were implemented.

The Administrator/Director of Care revealed that the homes policy number: NA-02-03-01, "Staff Patterns," last reviewed and revised March 1, 2007, is what the home refers to as their staffing plan. During interview conducted with the Administrator/Director of Care they acknowledged that the home did not complete a written record related to the evaluation of this staffing plan. In addition there is no evidence of any changes and dates of implementation.

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log # 003731-17, conducted concurrently during this RQI. [s. 31. (4)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared.
O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act or the Regulation.

During an interview conducted with the Administrator/Director of Care on October 12, 2017, they acknowledged that they did not complete an evaluation of their restraints policy since their start date at the home in 2016. They acknowledged that the previous Administrator/Director of Care may have completed an evaluation of the program, however were unable to produce a written record of the evaluation.

The home did not ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of their restraints policy, and what changes and improvements were required. [s. 113. (b)]

Issued on this 2nd day of November, 2017

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

Original report signed by the inspector.