Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2020	2020_573581_0003	023792-19	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres II GP Inc.
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

DIANNE BARSEVICH (581)

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): February 7, 10 and 11, 2020.

The following intakes were inspected:
Critical Incident System (CIS) inspection, log number 023792-19 related to falls preventions and management.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Acting Director of Care (Acting DOC), Registered Nurses (RN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector reviewed the clinical health records and reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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	Légende 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 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 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 policy, the licensee was required to ensure that the policy, was complied with.

In accordance with Ontario Regulation 79/10, section 48(1) 1 the licensee was required to have an interdisciplinary falls prevention and management program developed to reduce the incidence of falls and the risk of injury.

Specifically, the licensee failed to comply with their policy, Head Injury Routine (HIR), identified as index I.D: RCS E-35 and last reviewed on July 10, 2018, which required registered staff to document for 72 hours on the Neurological Flow sheet the resident's vital signs. Vital signs were to be checked and recorded every 15 minutes for the first hour, every 30 minutes for the next two hours, every hour for the next five hours, every four hours for the next 16 hours and every eight hours for 48 hours.

Review of the clinical record identified that resident #001 had an unwitnessed fall on an identified date in December 2019 and sustained an injury.

Following a review of the clinical record with the Acting Director of Care (ADOC), they stated that it was the home's procedure for registered staff to complete the HIR after all falls that were unwitnessed and confirmed that the HIR was not initiated post unwitnessed fall for resident #001 on a specified date.

The ADOC confirmed that the licensee's policy, Head Injury Routine was not complied with. [s. 8. (1) (a),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 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 policy, the licensee was required to ensure that the policy, was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the physical functioning, and the type and level of assistance that was required relating to activities of daily living, including hygiene and grooming.

The licensee's policy, Assessment and Documentation for Lifting, Transferring and Repositioning, identified as index I.D: HS O-40 and last revised on June 1, 2019, directed registered staff to assess each resident on admission and at a minimum quarterly to identify their status regarding weight bearing and mobility and determine needs related to transferring, lifting and repositioning.

Specifically, on admission, " the registered staff assesses the resident's functional ability to ambulate and transfer within (24 hours). A determination is made based on this assessment as to the degree of supervision and/or assistance required and the type of lift required. The register staff documents this information on the resident's care plan. The results of each resident's assessment must be documented and include both risk

factors and current level of assistance. A more in depth physio/rehab assessment is done on admission to determine the resident's mobility and transferring needs. Once the physio assessment is completed and the interventions are documented on the care plan it must be communicated to the appropriate staff for implementation." "There is documented evidence that all resident are assessed for mobility and transferring functional abilities on admission, whenever there is a significant change in health status and at a minimum on a quarterly basis."

Review of the plan of care for resident #001 identified there was no Transfer and Lift Assessment completed by the registered staff or Physiotherapist (PT) when the resident was admitted in 2019 and when the resident's transfer status changed within nine days after admission.

In an interview and following a review of the clinical record with the Acting DOC, they stated upon admission, quarterly and any change in transfer status, registered staff in collaboration with the Physiotherapist (PT) were to complete the Transfer and Lift Assessment. They acknowledged there was no interdisciplinary assessment by the registered staff or PT documented in the plan of care when the resident was admitted or when their transfer status changed.

The Acting DOC confirmed that the Transfer and Lift Assessment was not completed by registered staff for resident #001 upon admission or when their transfer status changed.

The plan of care was not based on, at a minimum, interdisciplinary assessment of the physical functioning and the type and level of assistance that was required relating to transfer assessments for resident #001. [s. 26. (3) 7.]

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 the plan of care was based on, at a minimum, interdisciplinary assessment of the physical functioning, and the type and level of assistance that was required relating to activities of daily living, including hygiene and grooming, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with resident, training in any other areas provided for in the regulations, specifically training in the area of falls prevention and management.

In accordance with O. Reg, 79/10, s. 221 (1) 1, annual retraining in the area of falls prevention and management is required.

The Executive Director (ED) provided records of staff training in the area of falls prevention and management. The documents provided indicated that 17 of 35 staff who provided direct care to residents (48 percent), did not receive training in the above noted area in 2019.

The ED and documents maintained by the home confirmed that not all staff who provided direct care to residents received the required training in Falls Prevention Management in 2019. [s. 76. (7) 6.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Review of the clinical record identified that on an identified date in December 2019, resident #001 had an unwitnessed fall. The initial assessment completed by registered staff identified there was no injury; however, a few hours later there was a change in their condition. On the same day the physician assessed the resident and ordered a specific diagnostic test which was performed the following day. The diagnostic test identified an injury and the physician ordered the resident to be transferred to the hospital for treatment.

The Acting DOC notified the Director through the submission of a Critical Incident Report (CIR) under the category, "Incident that caused an injury to the resident for which the resident was transferred to hospital and which resulted in a significant change in the resident's health status," five business days following the resident's transfer to hospital.

Following a review of the clinical record with Acting DOC, they confirmed the Director was not notified within one business day of an incident that caused an injury to resident #001 for which they were transferred to hospital and resulted in a significant change in the resident's health condition. [s. 107. (3) 4.]

Issued on this 13th day of February, 2020

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

Original report signed by the inspector.