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
Nov 3, 2021	2021_914196_0005	010685-21, 015278-21	Complaint

Licensee/Titulaire de permis

Board of Management of the District of Kenora
1220 Valley Drive Kenora ON P9N 2W7

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

Pinecrest (Kenora)
1220 Valley Drive Kenora ON P9N 2W7

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.

This inspection was conducted on the following date(s): October 5, 6, 7, and offsite October 12, 2021.

The following intakes were inspected during this Complaint inspection:
-one intake related to resident care concerns; and
-one intake related to improper resident care.

Critical Incident System (CIS) Inspection #2021_914196_0006 was conducted concurrently with this Complaint inspection.

Inspector #721027 attended this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Nurse Practitioner (NP), Physiotherapist (PT), Physiotherapy Assistant (PTA), Housekeeping Aide, Environmental Services Manager (ESM), Resident Assessment Instrument (RAI) Coordinator, a complainant and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, observed staff to resident interactions, reviewed relevant resident health care records, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Pain
Personal Support Services
Skin and Wound Care

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

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

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The health care records for resident #001 indicated the development of an area of impaired skin integrity on a specific date. The records identified the date the SDM became aware of the impaired skin integrity.

The DOC confirmed that resident #001's SDM had not been notified immediately or within a reasonable time, of the development of an area of impaired skin integrity and should have been.

Sources: Resident #001's progress notes; and interviews with the Nurse Practitioner (NP), DOC and the SDM. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan.

Resident #001's health care records indicated that a therapeutic device was to be applied in the morning and removed at bedtime. In addition, the current care plan noted that the resident was to be assisted with the application and removal of their therapeutic device, a.m. care and at HS (bedtime).

Resident #001 was observed with a therapeutic device on one part of their body. There was no therapeutic device in place on another area of the resident.

PSW #103 reported that they could only find one therapeutic device that morning and put that on the resident. Together with the inspector, PSW #103 checked the in their room and found two complete sets of therapeutic devices and one individual therapeutic device.

Sources: Record review of Pharmacy order sheet; care plan; Observations of resident #001; and interviews with PSW #103, PSW #104 and the resident's SDM. [s. 6. (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 that ensures the resident's substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care and ensures that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules were complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The doors to a utility room were observed open and unlocked. Additionally, a treatment room was observed to be open and unlocked and there were no staff present in or around the area. On the treatment room door there was a sign posted that read, “PLEASE KEEP THIS DOOR CLOSED AT ALL TIMES”.

PSW #103 acknowledged that the utility room door should always be closed and locked.

The DOC confirmed that doors to non-residential rooms, treatment and utility rooms, were to be closed and locked.

Sources: Observations of a unit at two separate times; Interviews with PSW #103 and the DOC. [s. 9. (1) 2.]

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 all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #001.

The health care records for resident #001 indicated for an activity of daily living, the assistance of two staff for transfers and the use of a specific specialized device.

PSW #104 reported that resident #001 was assisted with an activity of daily living, and a different type of device was used.

PSW #103 reported that staff sometimes used a different type of device for assisting the resident with an activity of daily living and would let the nurse know they were using this type of device.

RN #105 indicated that resident #001 required a specific specialized device.

Sources: Review of resident #001's current care plan and "LIFTING AND TRANSFERRING ASSESSMENT"; Interviews with PSW #103 and #104, RN #105 and the SDM. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting resident #001, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

The health care records for resident #001 indicated that they used a containment product; and they were to be assisted with an activity of daily living on a schedule.

Observations were conducted of resident #001 over a 1.25 hr time period for staff assistance with an activity of daily living.The resident was not assisted with the activity if daily living during this time period.

PSW #104 reported they were not sure if resident #001 was assisted with an activity of daily living after lunch.

PSW #103 reported that resident #001 was not assisted with an activity of daily living at around a specific time.

The DOC confirmed that the resident #001 was to be assisted with an activity of daily living according to the schedule as specified in the care plan.

Sources: Review of care plan; Observations of resident #001 over a 1.25 hours time period; Interviews with the SDM, PSW #103 and PSW #104 and the DOC. [s. 51. (2) (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 ensured resident #001 who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #002 had been experiencing pain as indicated in the PSW flow sheets over an approximate one month time period. The progress notes during this same time period indicated pain and discomfort in various body areas and at different times. The physician orders included changes to dosages and types of analgesia.

The health care records were reviewed and a pain assessment was conducted using a clinical tool on one date. There were no further pain assessments completed from that date through to another date.

The DOC confirmed that a pain assessment should have been conducted at minimum once during that time period.

Sources: Interview with the DOC; review of resident #002 health care records; review of the home's policy titled, "Pain management protocols - NUR-130", last revised 05/21". [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program, specifically assist residents with hand hygiene before meals.

Observations were conducted of a lunch service and a dinner service. Resident hand hygiene was not performed at the start of either meal service.

PSW #100, and RPN #102, confirmed that hand hygiene had not been provided to the residents prior to the meal service.

The home's policy titled, "IPAC Routine Precautions OHS 410 - last revised 12/20" read that "Staff must assist residents to wash their hands: after toileting, or covering a cough or sneeze, or wiping the nose, before and after meals" and "Alcohol hand-rinse may be used instead of soap and water, except when hands are visibly soiled".

Sources: Observations of a lunch and dinner service; Interviews with PSW #100, PSW #103, RPN #102 and the DOC; Review of the home's policy titled, "IPAC Routine Precautions OHS 410 - last revised 12/20". [s. 229. (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 all staff participate in the implementation of the infection prevention and control program and assist all residents with hand hygiene before meals, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a comfortable easy chair was provided for every resident in the resident's bedroom, or that a resident who did provide their own comfortable easy chair was accommodated in doing so.

Resident #001's room was observed and did not have a comfortable easy chair.

The SDM reported that the resident did have a recliner chair in their room but that it had been removed.

PSW #106 reported that this resident used to be put into their recliner but there was no space in the room when they started with the Griffin lift.

RN #105 reported that when resident #001 had a change in their physical condition and a change in their activity of daily living there was no room for the chair and it was removed.

Sources: Observations of resident #001's room, observations of four additional resident rooms, on a unit; Interviews with the SDM, the DOC, PSW #106 and RPN #102. [s. 12. (2) (e)]

Issued on this 5th day of November, 2021

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

Original report signed by the inspector.