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
Jan 20, 2022	2022_945027_0001	015632-21, 015817-21, 016904-21, 017055-21, 017284-21, 018417-21, 020028-21	Critical Incident System

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

CHRISTOPHER AMONSON (721027), MELISSA HAMILTON (693)

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): January 10 to 13, 2022.

The following intakes were inspected on during this Critical Incident System (CIS) inspection:

-one intake related to an alleged visitor to resident abuse;
-four intakes related to falls;
-one intake related to alleged improper care; and
-one intake related to a missing resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Practical Nurse (RPN), Personal Support Workers (PSWs) a Housekeeper and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed Infection Prevention and Control (IPAC) practices, reviewed relevant health care records, reviewed the home's internal investigation notes, and reviewed licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. (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 a resident’s substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident’s care plan.

A resident had a medical condition which required the involvement of their SDM to make decisions regarding their care. A decision was made to discontinue an intervention for the resident and was subsequently removed without notifying the SDM. While an interdisciplinary meeting was held to discuss the removal of the intervention, the SDM was not provided the opportunity to be involved in the decision-making process. Instead, the SDM found out when they went to visit the resident and were informed of the discontinuation by staff.

Sources: CIS report, resident progress notes and care plan, LTC policy titled “Care Plans, NUR 110” (revised December, 2021), interviews with staff. [s. 6. (5)]

2. The licensee has failed to ensure the written plan of care for a resident was reviewed and revised.

A resident had a history of a specific behaviour. The resident was able to manually open the door at the main entrance. An alarm was activated when the door was manually opened, but staff silenced the alarm without investigating or reporting the incident. The resident exited the building and was brought back to the home by an outside agency a number of hours later.

The DOC acknowledged that the resident had previously demonstrated these behaviours, however the resident's care plan did not include any reviews and/or revisions.

Sources: CIS report, resident’s progress notes, LTC policy titled “Safety and Security of the Resident, ADM 455” (revised December, 2021), and interview with staff. [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 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; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective, to be implemented voluntarily.

Issued on this 21st day of January, 2022

[redacted]

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

Original report signed by the inspector.