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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 1, 2015	2015_217137_0052	031516-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

PINECREST MANOR
399 BOB STREET P.O. BOX 220 LUCKNOW ON N0G 2H0

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

MARIAN MACDONALD (137), DONNA TIERNEY (569), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 23-27 and 29, 2015

A Critical Incident Inspection (CIS), under Log # 024847 and CIS # 2600--000014-15, related to falls was completed in conjunction with the Resident Quality Inspection (RQI).

During the course of the inspection, the inspector(s) spoke with Executive Director/Director of Care, Associate Director of Care, Recreation Manager, Dietary Manager, Environmental Services Manager, Business Office Manager, three Registered Nurses, three Registered Practical Nurses, six Personal Support Workers, one Physiotherapy Assistant, one Recreation Aide, one Dietary Aide, Residents' Council Representative, three Family Members and 40 + Residents.

The Inspectors also toured resident home areas, common areas, medication storage area, observed dining service, care provision, resident/staff interactions, recreational programs, medication administration, reviewed residents' clinical records, relevant policies and procedures, staff education records and various meeting minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council

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

- **3 WN(s)**
- **3 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. (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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A Fall Risk Assessment identified an individual resident as being at medium risk for falls. The resident sustained recent falls but there was no documented evidence that falls and fall prevention interventions/strategies were identified on the plan of care.

During an interview, the RAI Coordinator/ADOC confirmed that falls and fall prevention interventions/strategies were not identified on the plan of care for an identified resident and the expectation was the plan of care set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that set out, clear directions to staff and others who provided direct care to the resident.

An identified resident was observed with a Personal Assistance Services Device (PASD) in place.

During an interview, it was revealed that the PASD had been consented to.

A review of the plan of care revealed there was no documented evidence related to the use of a PASD.

During an interview, with the RAI Coordinator/Associate Director of Care, it was confirmed that there was a PASD in place and that it should be documented in the plan of care.

The Executive Director/Director of Care confirmed that it was the home's expectation that all PASD's would be documented in the residents’ plan of care. [s. 6. (1) (c)]

3. The licensee has failed to ensure that there was a written plan of care for each resident that set out, clear directions to staff and others who provided direct care to the resident.

A second identified resident was observed with a PASD in place.

During an interview, it was revealed that the PASD had been consented to.

A review of the plan of care revealed there was no documented evidence related to the use of a Personal Assistance Services Device (PASD).

During an interview, with the RAI Coordinator/Associate Director of Care, it was confirmed that there was a PASD in place and that it would be documented in the plan of care.

The Executive Director/Director of Care confirmed that it was the home's expectation that all PASD's would be documented in the residents’ plan of care. [s. 6. (1) (c)]

4. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A review of the plan of care, for an identified resident, revealed no documented evidence

identifying the provision of oral health care.

The RAI-MDS Coordinator/ADOC confirmed oral health care was not identified on the plan of care and the expectation was that the plan of care set out clear directions for staff and others who provided direct care to the resident. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A review of the plan of care plan, for one identified resident, revealed that the call bell was to be placed within reach of the resident.

An interview revealed that the identified resident does not use the call bell.

An interview, with RAI Coordinator/Associate Director of Care, confirmed that the resident does not use the call bell. The RAI Coordinator/ADOC confirmed that the plan of care did not reflect the resident care needs regarding the call bell.

The Executive Director/Director of Care confirmed that it was the home's expectation that the plan of care would be based on an assessment, needs and preferences of the Resident. [s. 6. (2)]

6. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of the plan of care plan, for another identified resident, revealed that the call bell was to be placed within reach of the resident.

An interview revealed that the resident was able to use the call bell but unable to do so independently if the call bell was not within reach.

A Personal Support Worker acknowledged that the call bell was not within easy reach for the resident and that it was the home's expectation that residents be able to reach the call bells.
A review of the Resident's care plan revealed that "Call bell and light pull cords be within easy reach and in a consistent location".

An interview with a Registered Nurse and the Executive Director/Director of Care

confirmed that it was the home's expectation that the care set out in the plan of care was provided to the resident as specified in the plan. [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 to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident and to ensure 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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings, and equipment were kept clean and sanitary.

Observations, throughout the Resident Quality Inspection (RQI), revealed dust build up in several resident washroom air vents. Cob webs were observed behind resident room entrance doorways, extending down the wall to the floor, and on bathroom ceilings.

A review of the home policies, from the Environmental Services Procedure Manual Section: Housekeeping Services, Index: ESP-C-115, Subject: General Cleaning - Daily Cleaning Schedule, dated September 2004, revealed under Procedure #1. "High dusting", #2. "General dusting and spot dusting", and #5. "Dust mop floor or vacuum".

Also, a review of policy Index: ESP-C-120, Subject: General Cleaning - High Dusting, dated September 2004, revealed under Procedure #2 "Dust all areas above head level", #3. "Check ceiling area, ceiling fixtures, picture frames and exhaust vents for cobwebs and dust", and under Frequency, "Once weekly as specified under weekly routines and/or as required."

During a tour, on November 30, 2015 at 1030 hours, the Environmental Services Manager (ESM) and the Executive Director (ED) confirmed the presence of dust build up in the bathroom vents, cobwebs behind resident doorways and on bathroom ceilings. Both shared it was the home's expectation that bathroom air vents and resident rooms be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Observations, during the initial tour and throughout the Resident Quality Inspection (RQI), revealed identified deficiencies such as damaged and paint chipped doors, door frames, walls and stained floors in 16 of 28 (57%) resident rooms.

The routine, preventive and remedial maintenance program schedule does not include painting and identified deficiency repairs.

During an interview, the Environmental Services Manager confirmed the identified deficiencies, as well as the expectation that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

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 home, furnishings, and equipment are kept clean and sanitary and are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that when a resident had fallen, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During a staff interview, it was revealed that an identified resident sustained a recent unwitnessed fall.

A record review revealed there was no documented evidence of a post-falls assessment completed for the resident following the fall.

Review of the home's policy: Fall Interventions Risk Management (FIRM) Program – Ontario, INDEX: LTC-E-60-ON, with a revision date of March 2014, revealed the following: "STANDARD OPERATING PROCEDURE Post Fall Management
1. Interdisciplinary progress notes (IDPN) will be completed as well as the Resident Post Fall Assessment Documentation [LTCE-E-60-25-ON]".

During an interview with the Executive Director, it was confirmed there was no post-fall assessment completed and it was the home's expectation that when a resident had fallen, a post-fall assessment was conducted. [s. 49. (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 to ensure that that when a resident has fallen, the resident is assessed and a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 2nd day of December, 2015

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

Original report signed by the inspector.