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 prévue 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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 2, 2019 | 2019_263524_0012 | 021776-17, 000011-18, 003773-18, 020860-18, 029835-18 | Critical Incident System |

### Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

### 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

INA REYNOLDS (524)

## 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): April 9, 10, 11 and 12, 2019.**

**The following critical incidents were completed within the inspection:**
**Log #021776-17 / CIS #2600-000018-17 related to prevention of abuse and responsive behaviours**
**Log #000011-18 / CIS #2600-000024-17 related to hospitalization and change in condition**
**Log #003773-18 / CIS #2600-000003-18 related to prevention of abuse and neglect**
**Log #020860-18 / CIS #2600-000008-18 related to skin and wound care**
**Log #029835-18 / CIS #2600-000015-18 related to prevention of abuse and responsive behaviours.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Food Service Manager, two Registered Nurses, the Registered Practical Nurse - Behaviour Support Ontario Lead, three Personal Support Workers, one Recreation Aide, one Housekeeping Aide and residents.**

**The inspector(s) also observed resident care provisions, resident and staff interactions, reviewed residents' clinical records including assessments and care planning interventions, and reviewed relevant policies and procedures related to this inspection.**

**The following Inspection Protocols were used during this inspection:**
**Hospitalization and Change in Condition**
**Nutrition and Hydration**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Skin and Wound Care**

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**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. (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 care set out in the plan of care was provided to the resident as specified in the plan.

This inspection was initiated as a result of a Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care on a specific date. Review of the CIS stated that a resident presented with identified symptoms for a number of days. The resident was transferred on a specific date for treatment and sent back to the home on the same day. The resident deceased in the home on a specific date and time.

Review of resident's clinical record showed the following:
-The quarterly Nutrition/Hydration Risk Identification tool completed on a specific date, identified that the resident was at nutritional/hydration risk.
-The plan of care under the nutrition focus indicated a goal that the resident was to maintain adequate food and fluid intake and to meet estimated fluid requirements of a specific amount in ml fluid/day until the next review date.
-The plan of care under the nutrition focus directed registered staff to complete a referral to the Registered Dietitian if the resident's fluid intake was less than required for three consecutive days.
-The "Daily Fluid Intake" report for a specific period of time, documented total 24 hour fluid intake for meals and snacks per day for the resident and showed less than requirements for multiple consecutive days.
-Staff documented on numerous occasions that the resident had been refusing fluids at meals and snacks.
-The progress notes on a specific date, documented that the resident was transferred for treatment at a specific time and was received back in the home on the same day at a specific time.
-There was no documented evidence that a referral was made to the Registered Dietitian as directed in the plan of care when the resident did not meet their fluid goal over a three day time period.

In an interview on a specific date, the Assistant Director of Care (ADOC) acknowledged there had been no referrals to the Registered Dietitian for the resident's low fluid intake. The ADOC agreed that the resident's plan of care directed staff to refer to the Registered Dietitian when fluid intake was less than required for three consecutive days and the home's expectation was that the care set out in the plan of care would be provided 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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**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 procedure, the procedure was complied with.

In accordance with LTCHA 2007, c. 8, s. 11 (1) (b), the licensee is required to ensure that there is an organized program of hydration for the home to meet the hydration needs of residents and with O. Reg. 79/10, s. 68 (2) (d), to ensure that the nutrition care and hydration program includes a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the licensee's "Nutritional Care and Hydration, LTC - Food and Fluid Intake Monitoring" procedure #CARE7-0.10.02 with effective date August 31, 2016, and review date March 31, 2019, which is part of the licensee's Nutritional Care and Hydration program. The procedure stated that: "the Unregulated Care Provider (UCP) documents food and fluid intake each shift, as required, including

activities and during the night shift. Nurse / delegate will review resident daily food and fluid intake".

A) Record review of the plan of care and Nutrition/Hydration Risk Identification Tool for a specific date, for an identified resident showed that the resident was at nutritional/hydration risk related to specific identified diagnoses.

Point of Care (POC) look back documentation in Point Click Care (PCC) was reviewed for a specific period of time, for the resident. Under the task "Fluid Intake - Meals and PRN" and "NUTRITION - ON – Snacks", the response to the follow up question "Fluids taken in cc's/mL's" was not always documented as follows:
Fluids – Meals – 12/48 (25 percent of the time)
Fluids – Snacks – 19/48 (40 percent of the time).

B) Record review of the plan of care and Nutrition/Hydration Risk Identification Tool for a specific date, for another identified resident showed that the resident was at nutritional/hydration risk related to a number of identified factors.

Point of Care (POC) look back documentation in Point Click Care (PCC) was reviewed for a specific period of time, for the resident. Under the task "Fluid Intake - Meals and PRN" and "NUTRITION - ON – Snacks", the response to the follow up question "Fluids taken in cc's/mL's" was not always documented as follows:
Fluids – Meals – 7/48 (15 percent of the time)
Fluids – Snacks – 12/48 (25 percent of the time).

In an interview on a specific date, a Registered Nurse (RN) verified that Personal Support Workers document fluid intake on POC for all meals and snacks. The RN said that registered staff would review the look back report for three days and if a resident's fluid intake was low they would be added to the dehydration list. A Personal Support Worker (PSW) told the inspector that they document the resident's intake electronically in POC. The PSW said that there were also options available in the POC to indicate if the resident refused or was not available.

In an interview, the Assistant Director of Care (ADOC) reviewed the "Daily Fluid Intake – ON" report with the inspector for the residents and acknowledged the missing documentation. The ADOC and a Food Service Manager agreed that the Registered Dietitian would not be able to accurately assess the nutritional risks and needs of residents with the missing documentation of the resident's fluid intake at each meal and

snack.

The licensee failed to ensure that the policy "Nutritional Care and Hydration, Food and Fluid Intake Monitoring" was complied with when fluid intakes were not always documented for the residents for a specific period of time. [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 requires the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the procedure is complied with, to be implemented voluntarily.***

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**Issued on this 2nd day of May, 2019**

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

**Original report signed by the inspector.**