Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: August 28, 2024
Inspection Number: 2024-1112-0005
Inspection Type: Proactive Compliance Inspection
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Pinecrest Manor, Lucknow

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 12 - 16, and 19 - 21, 2024.

The following intake was inspected:

- Intake: #00121339 - Proactive Compliance Inspection

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Food, Nutrition and Hydration

Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The licensee failed to ensure that the recreation room door leading to a secure outside area that precluded exit by a resident, was equipped with a lock to restrict

unsupervised access to those areas by residents.

Rationale and Summary
A staff member showed an Inspector that the recreation room door can be locked and unlocked from the inside by turning the thumb turn lock. Residents would be able to lock and unlock the door themselves.

On a later date of inspection, the thumb turn lock was replaced with a key lock, and the keys were kept by the nurses and managers.

Sources: Inspector observations; Interviews with the Environmental Service Manager (ESM), Executive Director (ED), and other staff.

Date Remedy Implemented: August 19, 2024

WRITTEN NOTIFICATION: ADVICE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee failed to seek the advice of the Residents' Council in carrying out the Resident and Family/Caregiver Experience Survey.

Rationale and Summary
Pinecrest Manor LTCH's head office created the 2023 Resident and

Family/Caregiver Experience Survey for 2023, and the LTCH did not seek the advice of the Residents' Council in carrying out the survey.

When the Residents' Council was not provided an opportunity to advise the home in carrying out the Resident and Family/Caregiver Experience Survey, their suggestions were not incorporated.

Sources: Residents' Council Meeting Minutes; Interview with the ED.

WRITTEN NOTIFICATION: DOCUMENTATION

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (b)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;

The licensee failed to ensure that the actions taken to improve the LTCH, and the care, services, programs, and goods based on the results of the Resident and Family/Caregiver Experience Survey, were documented and made available to the Residents' Council.

Rationale and Summary
According to the results of the 2023 Resident and Family/Caregiver Experience Survey 2023, some of the opportunities for improvement that needed to be actioned included the quality of care from social workers, quality of care from

doctors, and opportunity to provide input on food and beverage options. The actions taken by the home to address these opportunities for improvement were not documented on the home's Workplan Quality Improvement Plan for 2024/25, and made available to the Residents' Council.

There was risk that the members of Residents' Council would not be aware of the actions taken based on the results of the survey.

Sources: 2023 Resident and Family/Caregiver Experience Survey, Workplan QIP 2024/25; Interview with the ED.

WRITTEN NOTIFICATION: LICENSEE OBLIGATIONS IF NO FAMILY COUNCIL

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)
Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee failed to convene semi-annual meetings to advise residents' families and persons of importance to residents, of the right to establish a Family Council.

Rationale and Summary
The ED indicated that there was no Family council established in the home.

The ED stated that the home would normally convene a meeting twice a year, to

advise residents' families and persons of importance to residents, of the right to establish a Family Council. The ED indicated that this meeting was only held once in 2023.

Sources: Family Council Information Session poster for September 12, 2023; Interview with the ED.

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (2)
Doors in a home
s. 12 (2) The licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The licensee failed to ensure that there was a written policy that dealt with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Rationale and Summary
The home had two doors that lead to a secure backyard. These doors were kept unlocked between certain daily hours for residents to be able to access the backyard whenever they wanted.

The home's Door Safety policy did not provide information regarding when these two doors must be unlocked or locked to permit or restrict unsupervised access to the secure backyard by residents.

By not having a written policy, there was risk for inconsistencies in terms of how staff members managed these doors.

Sources: Inspector observations; Door Safety Policy #CARE10-O10.07 reviewed on March 31, 2024; Interview with the ED.

WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

A review of the home's air temperature tracking sheets for two months in 2024 indicated the temperature was not maintained at a minimum temperature of 22 degrees Celsius on multiple days in three resident bedrooms and the home's dining room. The recorded temperatures ranged from 18 degrees to 21 degrees Celsius.

There was risk for resident discomfort when the air temperatures were not maintained at a minimum temperature of 22 degrees Celsius.

Sources: Air Temperature Tracking Sheets for two months in 2024; Interview with

the ESM.

WRITTEN NOTIFICATION: Menu planning

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (e)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) includes a choice of other available entrées and side dishes at all three meals and a choice of other desserts at lunch and dinner, to meet residents' specific needs or food preferences;

The licensee failed to ensure the 2024 Spring Summer menu cycle included an alternate choice for all entrees and sides.

Rationale and Summary
On May 27, 2024, the 2024 Spring Summer base menu cycle was implemented at the home.

During the inspection, one resident expressed frustration with the repetition of side offerings in the current menu, particularly at dinner meals. A different resident said they had received multiple meals from the recent menu where there was only one option for the side, such as salads and potatoes.

Seven meals were identified in the 2024 Spring Summer regular texture menu cycle of only one choice for meal sides, including potato and salad dishes.

When the menu cycle did not include an alternate option for sides at all meals, residents were denied the opportunity to choose their preferred meals.

Sources: Interviews with residents, as well as the home's Food Service Manager (FSM) and other staff; Records including the home's Spring/Summer 2024 menu cycle.

WRITTEN NOTIFICATION: Menu planning

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (a)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(a) is reviewed by the Residents' Council for the home;

The licensee failed to ensure the Spring Summer 2024 menu cycle was reviewed with Resident's Council prior to implementation.

Rationale and Summary
The home received a 2024 Spring Summer menu cycle on April 2, 2024.

The menu was not reviewed with the Residents' Council of the home prior to implementation on May 27, 2024.

When the Residents' Council was not given an opportunity to review the 2024 Spring Summer menu prior to its implementation, residents' preferences were not proactively captured in the menu.

Sources: Interview with a Residents' Council Member, as well as the home's FSM and other staff; Records including the home's Resident Council Meetings Minutes.

WRITTEN NOTIFICATION: Menu planning

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure a written record was maintained of the home's 2024 Spring Summer menu cycle evaluation in accordance with regulations.

Rationale and Summary
At the time of inspection, the home's FSM reported a written record had not been maintained of the 2024 Spring Summer menu cycle evaluation process that included the FSM's participation, as well as the date of their evaluation, and a summary of the changes made.

When a full written record was not maintained of the menu cycle's evaluation, it impeded efficient review and collaboration within the dietary department for menu planning.

Sources: Interview with FSM and other staff; Records including the home's 2024 Spring Summer menu cycle evaluation documents.

WRITTEN NOTIFICATION: Menu planning

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure planned menu items were offered and available at each snack.

Rationale and Summary
On a date of inspection, the afternoon snack carts from both wings of the home were observed to not contain planned menu items.

A) Neither the North Wing or East Wing afternoon snack carts were observed to contain an assortment of fresh fruit, as indicated on the snack menu for that date.

The Food Service Worker (FSW) who prepared the snack cart said they did not put out the fruit on either cart because the grocery order hadn't come in.

The home's FSM said there were assorted fruits in the fridge on that date, and the FSW should have put them onto the snack carts to ensure the planned menu snacks were offered to residents.

B) Across both North and East Wings of the home, five residents had a diet texture intervention.

Neither afternoon snack cart contained any snack for that diet texture, as indicated on the therapeutic menu for that day.

The FSW who prepared the snack cart said they forgot to put those snacks on the afternoon carts that day, as the kitchen had been busy with receiving a grocery order.

The home's FSM said the FSW should have put the texture-modified snacks on the cart as per the planned menu.

When snacks were not available on the snack cart as per the planned menu for afternoon snack service on a date of inspection, multiple residents were denied a snack.

Sources: Inspector observations; Review of snack menus; Interviews with the home's FSM, and a FSW.

WRITTEN NOTIFICATION: Dining and snack service

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee failed to ensure FSW staff were aware of a resident's dietary intervention.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee was required to ensure that any plan, policy, protocol, program, procedure, strategy, initiative or system, was complied with.

As per Meal Service Policy CARE17-P40, last reviewed March 31, 2024, staff were to be attentive to residents' needs during meal service, including awareness of residents' diet, special needs, and preferences.

Rationale and Summary
A resident required a dietary intervention to support increasing the resident's intake.

Several weeks after the dietary intervention had been added to the resident's care plan, two regular food service workers said they did not realize the update had been made. They said they had not been providing the dietary intervention to the resident. They noted the home's system for communicating the update did contain the message regarding the update to the resident's dietary needs, though they had not recognized it at the time.

When the resident did not receive their dietary interventions over several weeks, they did not receive a prescribed nutritional intervention to support management of their nutritional risk.

Sources: Interviews with a resident's POA, as well as FSWs and other staff; a resident's clinical records, as well as Meal Service Policy CARE17-P40, last reviewed March 31, 2024.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to the Infection Prevention and Control (IPAC) was implemented.

In accordance with 10.2 c) of the IPAC Standard for Long-Term Care Homes, last revised September 2023, the home's hand hygiene program shall include assistance for residents to perform hand hygiene before meals and snacks.

Rationale and Summary
On three separate days during the inspection, PSW staff were observed to not offer residents assistance with performing hand hygiene when the residents were served finger food snacks.

The home's procedures on Hand Hygiene, (Policy ID#IPC2-O10.14,) directed staff to assist residents with hand hygiene prior to snacks.

Failure to offer residents assistance with hand hygiene prior to residents eating finger foods during afternoon snack service increased risk of infection transmission.

Sources: Inspector observations; Interviews with PSW staff; Policy 'Resident Hand Hygiene' ID IPC2-O10.14, last revised March 31, 2024.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that the Continuous Quality Improvement (CQI) initiative report contained a written record of how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the members of the staff of the home.

Rationale and Summary
The ED stated that the results of the survey were shared to the staff members during huddles.

The home's CQI initiative report did not include the above-mentioned information and the dates when the results of the survey were shared to the members of the staff of the home.

Sources: Resident and Family/Caregiver Experience Survey 2023, QIP 2024, Workplan QIP 2024/25; Interview with the ED.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee failed to ensure that the CQI initiative report contained a written record of the actions taken to improve the LTCH, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions.

Rationale and Summary
According to the Resident and Family/Caregiver Experience Survey 2023, some of the opportunities for improvement that needed to be actioned included the quality of care from social workers, quality of care from doctors, and opportunity to provide input on food and beverage options. A written record of the actions taken by the home to improve on these areas was not included in the home's CQI initiative report.

When there was no record maintained in the home that documented the actions taken, as well as the dates the actions were implemented and the outcomes of the actions, the status of the home's action plans and goals were unclear.

Sources: Resident and Family/Caregiver Experience Survey 2023, QIP 2024, Workplan QIP 2024/25; Interview with the ED.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that the CQI initiative report contained a written record

of how, and the dates when, the actions taken under O. Reg. 246/22, s. 168 (2) 6 (i) and (ii) were communicated to the members of the staff of the home.

Rationale and Summary
The ED indicated that the actions taken under O. Reg. 246/22, s. 168 (2) 6 (i) and (ii) were shared to the staff members during huddles and the strategic planning process.

The home's CQI initiative report did not include the above-mentioned information and the date when the actions taken by the home were shared to the members of the staff of the home.

Sources: Resident and Family/Caregiver Experience Survey 2023, QIP April 2, 2024, Workplan QIP 2024/25; Interview with the ED.