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
Feb 14, 2022	2022_815623_0001	001623-22	Proactive Compliance Inspection

Licensee/Titulaire de permis

Medlaw Corporation Limited
3418 County Road 36, R.R. #2 Bobcaygeon ON K0M 1A0

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

Pinecrest Nursing Home (Bobcaygeon)
3418 County Road 36, R.R. #2 Bobcaygeon ON K0M 1A0

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

SARAH GILLIS (623), CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): January 31, February 1 - 4 and 7, 2022

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aid (DA), Physiotherapy Assistant (PTA), Activation Assistant (AA), Maintenance, COVID Screener/Tester, Resident Council President, Residents and Families.

During the course of the inspection, the Inspectors toured the home, reviewed IPAC program, Quality Improvements and satisfaction survey, Skin and Wound care program, Falls and Prevention Program, Pain management, clinical health records of identified residents and Prevention of Abuse program. Observed IPAC practices, meal services, medication administration and staff to resident interaction and provision of care.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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

4 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	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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents are bathed, at a minimum, twice a week by the method of his or her choice.

Record review of resident #003, #005 and #006's bathing records indicated that for the look back period a number of baths were not provided.

PSWs #118, #119 and #120 confirmed that the residents baths were not being completed because of being short staffed. DOC confirmed that they were aware resident baths were being missed related to the lack of staffing and having one of the homes baths under repair.

Source: Bathing records for resident #003, #005 and #006 and staff interviews (DOC, Administrator, PSW #118, #119 and #120) [s. 33. (1)]

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 by ensuring that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #2: 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 failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Inspector #623 discovered resident #002 alone in their room, sitting in a mobility device, the full sling was underneath the resident and attached to a mechanical lift. The Inspector waited and no one returned to the room. RN #114 was notified, they attended the room and unhooked resident #002 from the mechanical lift. PSW #116 indicated they had connected the resident's sling to the lift and left the room to assist another resident.

During an interview PSW #116 indicated they were unaware they could not leave a resident with the sling attached to the lift. RN #114 indicated that a resident should not be unattended while connected to the lift and two staff should be present when the lift was in use.

The DOC confirmed that PSW #116 had received training upon hire for the homes Minimal Lift Policy as well as annually. The DOC indicated the expectation was that a resident would not be left unattended while connected to the mechanical lift using a sling and that two staff would be present to perform all lifts.

When resident #002 was left unattended and attached to the mechanical lift, they were at risk of injury.

Source: Observations, Staff interview, Policy: Minimal Lift Program, education records. [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 by ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that the infection prevention and control program required under subsection 86 (1) of the Act complies with the requirements of this section. O. Reg. 79/10, s. 229 (1).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control Program is evaluated and updated at least annually in accordance with evidence-based practices.

On January 31, 2022, Inspector #194 observed Alcohol Based Hand Rub (ABHR) in the south unit, with 60% v/v ethyl alcohol concentration. DOC stated that they were not aware that the ABHR being used at the home had 60% ethyl alcohol concentration.

Review of the Ontario Public Health "PIDAC best practices for hand hygiene in all settings, 4th edition directed:
ABHRs available for health care settings range in concentration from 60 to 90% alcohol. Concentrations higher than 90% are less effective because proteins are not denatured easily in the absence of water. Norovirus and other non-enveloped viruses (e.g., rotavirus, enterovirus) are a frequent cause of gastroenteritis outbreaks in health care facilities. Studies suggest that norovirus is inactivated by alcohol concentrations ranging

from 70% to 90%. Since norovirus is a concern in all health care settings, this should be taken into consideration when choosing an ABHR product. A minimum concentration of 70% alcohol should be chosen.

The licensee's Hand Hygiene program/policy (last updated in 2021) directed that the ABHR could contain a variety of alcohols in concentrations from 60%-90.

Failing to ensure that the Infection Prevention and Control Program is evaluated and updated annually with evidence-based best practices, increases the risk of infections at the home.

Sources: Ontario Public Health "PIDAC best practices for hand hygiene in all settings", 4th edition, observations at the home and staff interview (DOC) [s. 229. (1)]

2. The licensee failed to ensure that the hand-hygiene program was complied with.

Review of the licensee's Hand Hygiene Program, directed that:
-In common areas where residents gather, to reduce the spread of organisms, residents, staff, volunteers and family members are to clean hands before beginning and after ending the activity. Some residents might need help cleaning their hands before they begin and after they end an activity.

-Hands of residents, staff, volunteers or family members are to be cleaned before assisting with meals or snacks.

Observations in the home on three separate dates, were completed by Inspector #623 and #194. PSW's were observed taking residents into the dining room for lunch, with no hand hygiene being provided. Residents were also observed leaving the dining room after the meal with no hand hygiene being provided.

PSW #111 confirmed that the hand hygiene was not completed for the residents as they were very busy and running behind. The DOC indicated the expectation was that residents would receive hand hygiene before and after the meal but was aware this was not consistently occurring.

When the licensee failed to ensure that the homes hand-hygiene program was followed, residents were placed at risk for infection.

Source: Observation of meal service, Hand-hygiene Program, Interview with staff (DOC, PSW #111). [s. 229. (9)]

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 by ensuring the homes Infection Prevention and Control Program is evaluated and updated at least annually in accordance with evidence-based practices, and by ensuring that the hand hygiene program is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During the medication observation a controlled substance medication vial was observed in the top drawer of the medication cart. RPN #102 confirmed that they had removed the vial from the locked box in the medication cart, and placed it in the top drawer of the medication cart when they entered the dining room prior to the meal service.

Failing to ensure that controlled substances are stored in a separate, double locked area of the medication cart, increases the risk of medication errors.

Source, observation of medication administration, interview with staff (RPN) [s. 129. (1) (b)]

Issued on this 14th day of February, 2022

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

Original report signed by the inspector.