Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: May 16, 2024	
Inspection Number: 2024-1227-0001	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Medlaw Corporation Limited	
Long Term Care Home and City: Pinecrest Nursing Home (Bobcaygeon), Bobcaygeon	
Lead Inspector Nicole Jarvis (741831)	**Inspector Digital Signature**
Additional Inspector(s) Patricia Mata (571)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1, 6, - 10, 2024
The inspection occurred offsite on the following date(s): May 2, 3, 2024

The following intake(s) were inspected:

- Follow-up #: 1 - CO #001 / 2023-1227-0001, FLTCA, 2021 - s. 33 (1) (b) - Policy to Minimize Restraining of Residents, CDD February 16, 2024.
- Complaint regarding resident care services
- Two Critical Incident Reports - regarding declared outbreaks

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1227-0001 related to FLTCA, 2021, s. 33 (1) (b) inspected by Nicole Jarvis (741831)

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee failed to ensure that resident #010 was provided with their hearing aids as set out in the plan of care.

Summary and Rationale

Resident #010's plan of care directed staff to obtain the resident's hearing aid from the registered staff as soon as the resident wakes up.

On one occasion the resident was assessed by the Physician. They did not have their hearing aids applied. On a separate occasion, the resident was observed by an Inspector to be missing their hearing aids although they were up and dressed and going to the dining room.

The RPN informed the inspector they were advised by staff that they were going in to get the resident up, but the RPN was busy, so they put in the resident's hearing aids in approximately 20 to 35 minutes later, when the resident was already in the dining room.

By failing to ensure the resident had their hearing aids in, the resident was at risk of not hearing what was said to them which could cause potential confusion, stress or agitation.

Sources: resident #010's clinical health records, observations, and interview with RPN #107. [571]

WRITTEN NOTIFICATION: Dietary services and hydration

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 15 (1) (b)
Dietary services and hydration
s. 15 (1) Every licensee of a long-term care home shall ensure that there is,
(b) an organized program of hydration for the home to meet the hydration needs of residents.

The licensee failed to ensure that their organized program of hydration for the home to meet the hydration needs of resident #010 was complied with.

Pursuant to O. Reg. 246/22, s. 11 (1) (b), the licensee must 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 a plan, policy, or protocol, the licensee is required to ensure compliance with the policy.

Rationale and Summary

Over a two month time period, there were two occurrences of Resident #010 not meeting a minimum of 1000mL of fluids for three consecutive days.

The licensee's policy indicates in the event a resident has consumed less than 1000 ml fluid for each of the last 3 days, the RN will: assess for signs and symptoms of dehydration, refer the Resident to Registered Dietitian for assessment and develop a plan of care which outlines the appropriate interventions to be implemented immediately (eg. push fluids, see above).

During a record review of the resident's clinical health records, there was no indication that the resident was assessed for signs and symptoms of dehydration and a referral was not sent to the Registered Dietitian. There was no indication that the team members were encouraged to 'push fluids' for the resident.

By failing to ensure the organized program of hydration for the home to meet the hydration needs was complied with, put the resident at risk of unidentified dehydration.

Sources: Clinical record review of resident #010, Policy: Hydration Program (Revised 03/22/2024) [741831]

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Rationale and Summary

During observations, several residents had a mechanical sling left under them while in the wheel chair during different occasions and days.

The Director of Care indicated that it requires two staff members to assist the resident to lean forward to remove or apply the sling which can be difficult for both the resident and hard on some of the staff. The Director of Care indicated if it was not easily removeable, then that would be the indication to leave the sling under the resident. The Director of Care indicated this information would not be found in the resident plan of care.

The slings were unidentifiable by the label observed by the inspector. The Director

of Care provided the manufacturers instructions for the slings in circulation. The Handicare Universal sling reads "Leave in place: Sling should only be left in place if they are made of spacer fabric. Other fabrics will increase the risk of skin breakdown if left under the patient for long periods of time. The decision to leave a sling in place must be based on strong clinical reasoning and the rationale should be documented. a trained professional should always perform a risk assessment to determine which sling should be used." The passive loop slings from Arjo Safety Patients sat out in a chair are at an increase risk of pressure injury development, due to high interface pressures concentrated over a small surface area when compared to lying in bed. An individualized skin and holistic assessment of the patient should be undertaken, before deciding on whether a sling should be left under a patient for any period of time.

The Director of Care indicated this was a red flag at the last inspection and intending to purchase "spacer" fabric to be left under the resident when required.

By failing to ensure all staff use equipment, specifically the mechanical slings put several residents at risk of altered skin integrity.

Sources: Observations, Manufacturers instructions, and interview with the Director of Care. [741831]

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure resident #010 was administered medication as prescribed.

Summary and Rationale

A review of the clinical records indicated that resident #010 did not receive their scheduled medication on two separate occasions as they were sleeping.

The RPN indicated that on both occasions, the resident had laid back down and they did not want to wake them. They did not call the SDM or Physician to inform them the medication was being held.

By failing to give medication as prescribed, the resident was at risk for a negative outcome.

Sources: resident #010's clinical records and interview with RPN #107. [571]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:

1) Conduct daily audits to ensure appropriate support is being provided for residents to perform hand hygiene prior to receiving meals and snacks and after toileting. These audits should be completed for two weeks or longer if compliance has not been reached. When deficiencies are identified in the audit corrective action needs to be taken, and a record of this is to be kept. Keep a documented record and make available to the inspectors immediately upon request.

2) Ensure Alcohol-Based Hand Rub (ABHR) is available at the point-of-care and ABHR dispensers should be mounted on the external wall immediately adjacent to the entrance to each patient/resident bedroom. Refer to Public Health Ontario, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition to ensure the appropriate placement of ABHR. Keep documentation of the ABHR added, removed or the procedure to ensure staff have ABHR at the point of care. Ensure the ABHR at point-of-care is communicated to staff. Keep documentation of the communication. Have all required documentation available for the inspector upon request.

Grounds

1. The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.
In accordance with the “Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022 (Revised September 2023)” (IPAC Standard) additional requirements section 10.4 The licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, which includes support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

Rationale and Summary

During observations within the long-term care home, staff were not observed assisting residents with hand hygiene prior to nourishment. The long-term care home was in an outbreak, which was declared on April 11, 2024.

The nourishment cart had no alcohol-based hand rub (ABHR) available for the staff to assist the resident and not portable ABHR in the residents room.

The Director of Care indicated the kitchen are to ensure the ABHR are on the carts.

After observing PSW #104 and PSW #105 provide nourishment to resident's, Inspector #741831 asked if the home had a procedure to assist resident with hand hygiene prior to providing resident's a snack. PSW #104 indicated that there is no practice in the home, only at meals.

PSW #103 was observed providing nourishment to an individual in isolation and the asymptomatic resident without offering or encouraging hand hygiene.

The IPAC lead indicated that the staff are required to support the residents with hand hygiene often including during nourishment.

The failure to ensure the staff support and encourage the resident with hand hygiene has the potential risk spreading infectious agents resulting in harm to residents, especially during an active outbreak.

Sources: Critical Incident Report, observations throughout the long-term care home, interview with the IPAC Lead and Director of Care. [741831]

2. The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

In accordance with the “Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022 (Revised September 2023)” (IPAC Standard) additional requirements section 10.1, the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas.

Rationale and Summary

During the initial tour, observations were made throughout the long-term care home. It was observed that all of resident rooms did not have alcohol-based hand rub (ABHR) stations available to staff and others immediately at point of care.

The Director of Care indicated they were involved in the placement of the ABHR. They indicated that an external source indicated that ABHR at the bedside or area of point of care was not required.

Public Health Ontario directs that ABHR needs to be available within arm’s reach of where direct care is being provided (point-of-care). Point-of-Care is described as the place where three elements occur together: the resident, the health care provider and care or treatment involving resident contact. The concept is used to locate hand hygiene products which are easily accessible to staff by being as close as possible, i.e., within arm’s reach, to where resident contact is taking place. Point-of-care products should be accessible to the health care provider without the provider leaving the zone of care, so they can be used at the required moment. (Best

Practices for Hand Hygiene in All Health Care Settings, 4th edition; dated April 2014. Public Health Ontario website at publichealthontario.ca).

The Director of Care indicated that staff do not carry ABHR on their person.

The North Wing was observed to have four wall mounted ABHR on the external wall, and three portable ABHR; which two were located by the wall dispenser on the same side of the hallway for 12 resident bedroom entrances. The South Wing has 16 bedroom entrances; there were four wall mounted ABHR on the external wall and all four portable ABHR hand pumps were located in the same location. Public Health Ontario indicates ABHR dispensers should be mounted on the external wall immediately adjacent to the entrance to each patient/resident bedroom. The inspector did not observe ABHR dispensers mounted on the external wall immediately adjacent to the entrance to each resident bedroom.

Failure of the licensee to have ABHR stations at point of care, within reach of staff and others, poses risk of harm, specifically the transmission of infections, to residents due to missed moments of hand hygiene, by staff, before, during and following resident care.

Sources: Observations of ABHR station placement in resident rooms, especially those under additional precautions; interview with the IPAC Lead. [741831]

This order must be complied with by August 12, 2024

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33 King Street West, 4th Floor
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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.