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
May 25, 2015	2015_198117_0014	O-002051-15	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 4) GP Inc. as a general partner of CVH (no. 4) LP, c/o Southbridge Care Homes Inc., 766 Hespeler road, Suite 301, Cambridge Ontario, N3H 5L8

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

PINECREST NURSING HOME (2797)
101 PARENT STREET P.O. BOX 250 PLANTAGENET ON K0B 1L0

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

LYNE DUCHESNE (117)

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): May 7 2015

During the course of the inspection, the inspector(s) spoke with the home's Administrator / Director of Care, several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), the home's RAI Coordinator and an identified resident. The inspector also reviewed an identified resident's health care record, reviewed a Critical Incident Report, observed resident care, a lunch time meal service and the afternoon collation pass.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (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 resident's plan of care is provided to the resident as specified in the plan of care.

Resident #1 has a neurodegenerative disease. The resident has been identified as having some swallowing difficulties and decreased mobility. The resident's plan of care dated February 2015 identified that the resident is to receive staff assistance when eating due to risks of choking. The plan also identifies that commonly used items, including the call bell, are to be within easy reach of the resident.

On a specified day in April 2015, Resident #1 was unwell due to an episode where he/she vomited undigested food. The next day, the resident's dietary needs were reassessed by the home's registered nursing staff. PSW staff were informed not to leave the resident unattended when eating food. The resident was closely monitored as was presenting with some respiratory wheezes. The attending physician was notified of the resident's condition, ordered oxygen for the next 2 days with close monitoring by nursing staff. Resident #1's family member was notified of the resident's change in health status as well as the medical orders for the use and application of oxygen.

One day later, in April 2015, Resident #1 was visited by his/her family member. The family member noted that the resident was seated in bed, oxygen in place, with an unfinished cookie at his/her side. The resident's call bell was on top of the oxygen compressor and not within the resident's reach. The family member called and notified the unit RN that the resident was not being supervised when eating and that the call bell was not within the resident's reach. The RN confirmed with the resident's family member that the resident's plan of care had not been implemented as directed in regards to eating supervision and the call bell being within reach.

On May 7 2015, PSW S#102, stated to Inspector #117 that she had given Resident #1 a cookie for the afternoon collation and confirmed that she had not stayed at the resident's side until such a time as the resident had finished eating his/her collation. The PSW stated that she had been aware that the resident required staff supervision when eating.

On May 7 2015, the home's Administrator / Director of Care stated to Inspector #117 that she had conducted an internal investigation into the above incident, in which the resident was left in his/her bed with some food and the call bell was not within the resident's reach. The Administrator confirmed that it was another PSW S#105 who had left the call bell on the oxygen concentrator, and not repositioned it within Resident #1's reach, when Resident #1 had requested to be transferred to his/her bed earlier that afternoon.

The Administrator confirmed that the care set out in Resident #1's plan of care was not provided as specified in the plan as it related to having staff supervision when eating and

having the call bell within the resident's reach at all times. [s. 6. (7)]

Issued on this 25th day of May, 2015

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

Original report signed by the inspector.