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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 15, 2016	2016_284545_0016	O-002785-15/O-002482-15	Complaint

Licensee/Titulaire de permis

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON 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

ANGELE ALBERT-RITCHIE (545)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 15, 16, 17 and 20, 2016

This Complaint inspection is related to two complaints:
Log #: O-002482-15 is related to medication administration, falls and care provision
Log #: O-002785-15 is regarding care provision, access to protected outdoor space, and sufficient staffing

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Clinical Nurse, Food Services Supervisor (FSS), Registered Dietician, RAI Coordinator, Office Manager, Activity Director, Activity Aides, Ward Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Workers (PSW), Behavioural Support Ontario staff (BSO), residents and families.

The inspector also conducted a tour of the resident care areas, reviewed residents' health care records, relevant home policies and procedures, staff work routines and schedules, staff orientation training, observed resident rooms, observed resident common areas, including the protected outdoor backyard, reviewed the home's staffing plan, and observed the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Personal Support Services
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

3 WN(s)
2 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 resident #015's SDMs were provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #015 was admitted to the home on a specified date in July 2014 with several medical conditions, including medication for behaviour management related to agitation and resistance to care.

A complaint letter dated a specified date in July 2015, written by resident #015's Substitute Decision Makers (SDM), addressed to the home with a copy sent to the Director under the Long Term Care Homes Act, was reviewed by the Inspector. In the letter, the SDMs expressed concerns regarding psychotic medication administration for behaviour management and finding the resident somnolent and lethargic.

According to RAI-MDS quarterly assessments completed from October 2014 to May 2015, it was noted that the resident wandered four to six days a week to daily and was resistive to care one to three days per week. The plan of care indicated that due to Alzheimer's Disease, resident #015, will sleep eight hours per night with medications as ordered and no sedation in the morning, administer anti-depressant medication as ordered and monitor for potential side effects and effectiveness, if resident refuses care, staff to leave and return at a later time to provide care.

In a progress note dated on a specified date in May 2015, it was documented that the resident's family members expressed concerns with the resident's medications,

indicating that they found the resident to be lethargic and not acting his/her normal self. There was no information to indicate the nurse's action plan.

During an interview with RPN #108 she indicated that she remembered the conversation with the resident's family members on a specified date in May 2015. She indicated that she believed she wrote a note on the physician's communication form to request a medication review and would have also notified the RAI Coordinator and/or the Clinical Nurse, however no written documentation to support that she notified them was found. The RPN further indicated that the resident's physician visited every second Tuesday, and based on the level of concern or urgency, nurses have the option to notify the physician immediately, but in this situation, she didn't think it was necessary to alert the physician until his next visit, which would be nine days later.

The Administrator/DOC indicated to the Inspector that it was the home's expectation that registered staff provided an opportunity for the resident's family to participate fully in the development and implementation of the plan of care, and in this situation the registered staff should have notified the physician immediately when the resident's family members expressed concerns regarding medications. [Log #: O-002482-15] [s. 6. (5)]

2. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Resident #015 was admitted to the home on a specified date in July 2014 with several medical conditions.

In a review of resident #015's health record, it was noted that the Extendicare Advance Directives' pink sheet was placed as the first page in the paper chart. The signature of the SDM was documented on two dates: the admission date, then 13 months later, to indicate the resident's advance directives option as: "Level Three - Transfer to Acute Care Hospital. If symptoms indicate, the resident would be transferred to an acute care hospital for treatment. Assessment would be made in the acute care hospital emergency department and a decision made whether to admit the resident or return him/her to the Extendicare facility. No cardiopulmonary resuscitation is requested and no admission to an acute care intensive care unit".

In a review of the electronic Medication Administration Record (eMAR), documentation of Advance Directives was noted as: Level 3 - Active treatment with transfer to hospital - DNR, by the resident's physician.

An orange sticker on the resident's paper chart indicated: DNR (Do Not Resuscitate) was observed.

In a review of the resident's progress note dated on specified date in January 2016, it was indicated that the resident was found in the activity room without vital signs. The note also indicated that RN #117 moved the resident in the hallway and started cardiopulmonary resuscitation (CPR) on resident #015; respiration restarted immediately. The note also indicated that upon review of the resident's chart, it was noted that the resident's Advance Directives were Level 3. The resident was sent to hospital via ambulance, family and physician were notified.

In a Discharge Summary note from the hospital dated on a specified date in January 2016, and it was noted that resident#015 was admitted. The resident was returned to the home with an increase in medication.

During an interview with RN #117, he indicated that he reacted by reflex when he was informed that the resident was without vital signs and started CPR. He indicated that the resident's chart should have been verified prior to starting CPR as the Advance Directives form was available in the front of the chart, as well as an orange sticker on the paper chart, and in the eMAR. He further indicated that a blue sticker identifying DNR also appears by the resident's bedroom door by the resident's name. [Log #: O-002482-15] [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 ensure that resident #015's Substitute Decision-Makers (SDM) be provided the opportunity to participate fully in the development and implementation of the plan of care and ensure that care set out in the plan of care, such as Advance Directives be provided to all residents as specified in the plan, to be implemented voluntarily.

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was implemented in accordance with all applicable requirements under the Act, and complied with.

In accordance with s. 11(1)b of the Act, every licensee of a long-term care home shall ensure that there is, an organized program of hydration for the home to meet the hydration needs of residents; and in accordance with O.Reg 79/10 s. 68(2)d every licensee of a long-term care home shall ensure that the programs include, a system to monitor and evaluate food and fluid intake of residents with identified risks related to nutrition and hydration.

The home's Food and Fluid Intake Monitoring, policy reference #: RESI-05-02-05, effective September 2014 was reviewed by the Inspector. Under the section Procedures the following was documented that "changes in food and fluid intake can serve as a key indicator of resident health and if changes occur, may require further assessment". It was also documented that:
Care Staff
(3) Report any concerns regarding resident's food or fluid intake to the Registered Staff including refusals items and supplements

Registered staff
(1) Review resident food and fluid intake records daily;
(2) If a Resident consumes less than their minimum fluid target levels for three consecutive days, the Resident requires a hydration assessment. The hydration assessment must be documented.
(3) If the hydration assessment indicates signs and symptoms of dehydration,

immediately implement strategies to increase fluid intake based on the needs and preferences of that resident
(4) Collaborate with the Dietary Manager, to implement strategies, as required

Registered Staff/Registered Dietitian
(1) Jointly review residents with changes from their normal food and/or fluid intake patterns, and discuss interventions with the resident, substitute decision make and/or family, and Care Staff.
(2) Monitor residents with consistently low fluid intake on an ongoing basis for signs and symptoms of dehydration
(3) Maintain a list of residents who consistently consume 50% or less of their fluid level identified by the Registered Dietitian and/or Registered Staff. In the absence of a dietitian, the physician is consulted.

Resident #001 was admitted to the home on a specified date in March 2015 with several medical conditions. According to the nutritional risk screening tool assessment conducted by the registered dietitian on admission, the resident was at high risk. Three months later, when reassessed by the registered dietitian, the resident was consuming 1300ml per day of fluid consistently and the risk level decreased to a moderate risk. Resident #001's daily fluid target goal was documented as: 1600-2200ml. A heat assessment conducted in April 2015 indicated that resident #001 was at high risk.

The written plan of care effective in August & September 2015 indicated that resident #001 required supervision, cueing and encouragement to eat and drink due to dementia, and to provide fluid to the resident, as often as requested and ensure to offer two cups of fluids at each meal and one cup at snack time.

A review of the progress notes revealed the following:
-on a specified date in August 2015, it was noted that resident #001 was brought to the emergency department with a change in condition.
-three days later, the resident was noted to have low blood pressure, and was encouraged to drink more fluids.
-ten days later, the Food Services Supervisor documented that resident #001 ate 41% of his/her meals as the resident was very anxious to come to the dining room with all the noise and everyone around; and drank 750ml daily which was under the requirements. No documented recommendations found.
-three days later, the resident was admitted to the hospital with another change in condition. The resident returned to the home eleven days later, with a specified blood

disease diagnosis.

In a review of the Resident Daily Food and Fluid Intake for the month of August 2015, fluid intake was documented as low, ranging from 360ml to 810ml per 24 hours, on 14 days in August 2015.

During an interview with the Food Services Supervisor, she indicated that it was the responsibility of the ward clerk or herself to monitor the Resident Daily Food and Fluid Intake sheet of every resident and highlight fluid total for any resident that consumed less than their minimum fluid target levels for three consecutive days. She further indicated that this process was intended to flag it to the RAI Coordinator who then checked the Resident Daily Food and Fluid Intake and conducted a Hydration Assessment to check for signs and symptoms of dehydration.

The RAI Coordinator indicated to the Inspector that it was her responsibility to monitor daily the Resident Daily Food and Fluid Intake and to conduct a Hydration Assessment as soon as possible when a resident consumed less than their minimum fluid target levels for three consecutive days. She reviewed resident #001's Daily Food and Fluid Intake, and indicated that a Hydration Assessment was conducted on August 31, 2015, however based on the low fluid intake on three to four consecutive days on two separate episodes in August 2015, a Hydration Assessment should have been conducted earlier, to detect signs and symptoms of dehydration and implement strategies. [Log #: O-002785-15] [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place be implemented in accordance with all applicable requirements under the Act, and complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement.

A family member indicated that resident #001 was not provided adequate assistance with eating and drinking in August and September 2015.

A review of the staffing schedules in August and September 2015, there was documentation that indicated that the home did not have a RN on duty for the following five shifts:
-August 9 - night shift
-August 21 - night shift
-August 22 - evening shift
-September 7 - day shift
-September 7 - night shift

The Office Manager indicated that an RPN was used to replace registered staff on those specific shifts, when a RN called to cancel their shift.

The Administrator/DOC indicated that up until December 2015, registered nurse coverage was more challenging and she was aware that there were several shifts where the RN was replaced with a RPN. She further indicated that on the night shifts of August 9, 21 and September 7, 2015, she would have come in for a few hours to provide nursing support to the covering RPN, however she was unable to provide documented record of number of hours worked for those shifts.

Currently the home does not have RN coverage issues, as evidenced by a review of the staffing scheduled for the period of April 29, 2016 to June 23, 2016, conducted by the Inspector. [Log #: O-002785-15] [s. 8. (3)]

Issued on this 19th day of July, 2016

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

Original report signed by the inspector.