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
Aug 9, 2021	2021_877632_0014	016303-20	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres II GP Inc.
3760 14th Avenue Suite 402 Markham ON L3R 3T7

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

Pine Villa Nursing Home
490 Highway #8 Stoney Creek ON L8G 1G6

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

YULIYA FEDOTOVA (632)

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): July 26-28 and August 3, 2021.

The following Critical Incident System (CIS) intake was completed:
log #016303-20 related to Prevention of Abuse and Neglect, Skin and Wound Care and Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Clinical Practice Co-ordinator, Associate Clinical DOC/Infection Prevention and Control (IPAC) Leader/Residents Assessment Instrument (RAI) Co-ordinator, Behaviour Support Ontario (BSO), personal support workers (PSWs), Personal Support Aid, registered nurses (RNs), registered practical nurses (RPNs), residents and their families.

During the course of the inspection, the inspectors toured the home and completed IPAC checklist and Cooling Air Temperature requirements inspection, observed residents and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other,
(a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Progress notes review indicated that a resident exhibited specified behaviour during an identified period of time. An identified assistance resources recommended specified actions to the home's staff.

The Responsive Behavior Philosophy program indicated the registered staff to review the specified recommendations and to follow up.

The resident’s clinical records review did not indicate that the specified recommendations were followed, which was confirmed by an RN.

The DOC indicated that the home’s staff needed to follow the specified recommendations.

The resident was at an identified risk as a result of staff involved in the specified assessment and management did not collaborate with each other.

Sources: the resident’s progress notes and other clinical records, the Responsive Behaviour Philosophy program; interview with the RN and the DOC. [s. 6. (4) (a)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents and should ensure that the policy was complied with.

A Critical Incident (CI) Report was submitted to the Director on an identified date, which occurred a day earlier in the home.

The home's Abuse and Neglect Policy indicated that where a staff member had a specified reason, they had immediately report their suspicion and the information upon which it was based, to the Home, and to the Director appointed under the Long-Term Care Homes Act, 2007.

The DOC indicated that once registered staff became aware about the incident, they were to call to the DOC and the incident was to be reported to the Ministry of Long-Term Care (MLTC).

An RN indicated that they completed an incident report but did not inform the DOC about the incident.

Sources: a CI Report, the Abuse and Neglect Policy; interviews with the RN and the DOC. [s. 20. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin tears, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Progress note indicated a resident’s specified altered skin integrity assessment documented on an identified date.

The Skin and Wound assessment tab contained documentation of specified altered skin integrity assessment conducted an identified number of days later.

The Skin Risk Assessment and Head-to-Toe Skin Assessment program indicated that registered staff would document the Wound Assessment in the resident's records following the protocol under the Skin and Wound tab in Point Click Care (PCC).

The DOC confirmed that the Skin and Wound tab was to be used for all altered skin integrity assessments.

The resident was at risk of altered skin integrity complications as they had not been assessed using clinically appropriate assessment instrument.

Sources: the resident’s progress notes and the Skin and Wound assessment tab, the Skin Risk Assessment and Head-to-Toe Skin Assessment program; interview with the DOC. [s. 50. (2) (b) (i)]

Issued on this 24th day of August, 2021

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

Original report signed by the inspector.