Ontario

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

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

Hamilton District
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Original Public Report

Report Issue Date: March 14, 2023	
Inspection Number: 2023-1244-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Rykka Care Centres II GP Inc.	
Long Term Care Home and City: Pine Villa Nursing Home, Stoney Creek	
Lead Inspector Lesley Edwards (506)	**Inspector Digital Signature** Lesley E Edwards Digitally signed by Lesley E Edwards Date: 2023.03.16 15:49:56 -04'00'
Additional Inspector(s) Lisa Vink (168)	

INSPECTION SUMMARY

The inspection occurred on the following dates:
March 1-3 and 6-9, 2023

The following intakes were inspected:
• Intake: #00021425 - Proactive Compliance Inspection (PCI).

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management

Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care for residents was revised at any time when their care needs changed and care set out in the plan was no longer necessary.

Rational and Summary
The plans of care for two residents included a red stop sign with the initials IPC for infection prevention and control, to alert staff.
A review of the March 2023, Infection Monitoring Case List identified two residents with a suspected infection since November 2022 and one resident with a suspected infection since January 2023.
The staff member acknowledged the residents no longer presented with infections and the plans of care were not revised with changes in care needs or when the care was no longer required.

Sources: Plans of care; progress notes; Infection Monitoring Case List for two residents and interview with staff.

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Date Remedy Implemented: March 2, 2023.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident provided clear directions to staff and others who provided direct care to the resident.

Rational and Summary
A resident required a mechanical lift and was to be repositioned every two hours according to their plan of care.
The plan did not provide clear direction to staff as to how to reposition the resident while up.
Repositioning observed did not include the use of the interventions identified.
Failure to ensure that the plan of care provided clear direction related to repositioning needs had the potential for care to be provided inconsistently.

Sources: Observations of a resident and a review of the plan of care; interviews with the resident and staff.

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WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the nutritional care was provided to a resident as specified in their plan of care.

Rationale and Summary
A resident was at nutritional risk and required a modified diet texture at all times according to their plan of care.
On an identified date in March 2023, the resident was observed during the meal being given liquid that was not modified. The registered staff acknowledged that the liquid was not modified as per the resident's plan of care.

Failure to provide the resident with the correct diet textures could have the potential to cause swallowing complications.

Sources: a resident's clinical record; resident observations and interview with staff.

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WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care for a resident was revised when their care needs changed or care set out in the plan was no longer necessary.

Rational and Summary
A resident had a decline in their health and a meeting was held on an identified date in 2023, to discuss their change in status and goals of care.
Review of the plan of care identified the resident was able to participate in some of their activities of daily living and these identified interventions and care needs were in place since 2022 and had not been revised with changes in the resident's care needs.
Failure to revise the plan of care when the resident's care needs changed or care was no longer necessary had the potential for staff to be unaware of care needs.

Sources: Observations and record review for a resident and interview with staff.

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WRITTEN NOTIFICATION: Retraining

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)

The licensee has failed to ensure that the persons who received training under subsection (2) received the retraining in the areas mentioned in that section at the intervals as provided for in the regulations.

Rational and Summary
FLTCA s. 82 (1) identified that all staff in the home were to receive training in the areas as required.
FLTCA s. 82 (2) identified that training was required in the areas, including: the home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 28 to make mandatory reports.
O. Reg. 246/22 s. 260 (1) identified the retraining was to be completed at annual intervals.

The home provided course completion training records for 2022 for staff training on the Abuse and Neglect Policy and a presentation on Resident Abuse and Neglect.
Review of the records identified that in 2022 only 88 per cent of the staff completed the required training.
There was a risk that not all staff were familiar with the home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 28 to make mandatory reports, when they did not receive annual retraining as required.

Sources: Training records; interviews with the ED and other staff.
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WRITTEN NOTIFICATION: Binding on Licensees

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational Minister's Directives that applied to the long-term care home, the operational Minister's Directive was complied with.

Rationale and Summary
In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee was required to ensure that regular Infection Prevention and control (IPAC) self-audits were conducted in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario.
The Minister's Directive stated that the home was to conduct regular IPAC self-audits following at a minimum the Public Health Ontario (PHO) COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes and Retirements Homes, every two weeks when the home was not in an outbreak, and once a week when in an outbreak.

A review of the completed audits identified that the home completed only one audit in December 2022 and failed to document any audits in February 2023.
Failure to complete IPAC audits at the required frequency had the potential for IPAC concerns to not be identified or addressed in a timely fashion.

Sources: Interview with iDOC; Minister's directives: COVID-19 response measures for long-term care homes dated April 27, 2022, and PHO's COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes.

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WRITTEN NOTIFICATION: General requirements

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to residents under the nursing services program, as required in FLTCA s. 11(1) were documented.

Rational and Summary
According to the plan of care for three residents they were to be showered twice a week. Bathing records for the past 30 days did not include documentation that the intervention was completed.
Two out of the three residents confirmed that they were showered twice a week and staff acknowledged that the interventions of bathing were consistently completed and the expectation that the care was documented in point of care (POC).
A review of POC did not include an area to document the task of routine bathing, only an area to record as needed bathing.

Sources: A review of the plan of care and POC records for three residents and discussion with staff.

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WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rational and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 to be followed in the IPAC program which included the appropriate selection, application, removal, and disposal of Personal Protective Equipment (PPE).
On an identified date in March 2023, a resident, had signage outside of their door which identified they were on precautions and how to don and doff PPE.
Two staff were observed to don and doff PPE during the provision of care to the resident.
Both staff donned gloves prior to any other PPE and when they doffed they removed their gloves after all other PPE.
One staff was also observed to complete hand hygiene with gloves on their hands.
On a review of the signage the staff acknowledged they did not follow the directions as posted.
Failure to don and doff as per IPAC standards may have increased the risk of transmission of infections.

Sources: IPAC Standard for Long-Term Care Homes; signage for a resident; observations of donning/doffing of PPE; interview with staff.

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WRITTEN NOTIFICATION: Additional training-direct care staff

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.

The licensee has failed to ensure that all staff who provided direct care to residents received training on falls prevention and management in 2022.

Rationale and Summary
Review of the home's training records for direct care staff on falls prevention and management identified that the training completion rate for 2022 was 85 per cent.

There was risk that all direct care staff may not be familiar with the home's falls prevention and management program when they did not receive annual training as required.

Sources: Training records; interview with ED and other staff.

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WRITTEN NOTIFICATION: Additional training-direct care staff

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.

The licensee has failed to ensure that all staff who provided direct care to residents received training on skin and wound care in 2022.

Rationale and Summary
Review of the home's training records for direct care staff on skin and wound care identified that the training completion rate for 2022 was 82 per cent.

There was risk that all direct care staff may not be familiar with the home's skin and wound care when they did not receive annual training as required.

Sources: Training records; interview with ED and other staff.

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WRITTEN NOTIFICATION: Additional training-direct care staff

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.

The licensee has failed to ensure that all staff who provided direct care to residents received training on pain management in 2022.

Rationale and Summary
Review of the home's training records for direct care staff on pain management identified that the training completion rate for 2022 was 75 per cent.

There was risk that all direct care staff may not be familiar with the home's pain management program when they did not receive annual training as required.

Sources: Training records; interview with ED and other staff.

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