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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 10, 2017	2017_633577_0020	022187-17	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive KENORA ON P9N 2W7

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

PINECREST
1220 VALLEY DRIVE KENORA ON P9N 2W7

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

DEBBIE WARPULA (577), LISA MOORE (613), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 16-20, 23-27, 2017

The following intakes were inspected:

Five Critical Incident System (CIS) reports the home submitted to the Director related to resident to resident abuse;

Three Critical Incident System (CIS) reports the home submitted to the Director related to resident falls; and

One Complaint submitted to the Director related to suspected resident to resident abuse.

During the course of the inspection, the inspector(s) conducted a tour of resident home areas, observed the delivery of care to residents, observed resident to resident and staff to resident interactions, reviewed resident health care records, and reviewed various home policies, procedures, and programs.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care ADOC), Resident Assessment Instrument (RAI) Coordinator, Environmental Services Supervisor, Administrative Secretary, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **6 WN(s)**
- **4 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

During Stage one of the Inspection, it was identified through a family interview, that resident #005 was observed to be incontinent many times and had to wait for continence care to be provided.

On a day in October 2017, Inspector #577 conducted a record review of resident #005's care plan and kardex which revealed nursing interventions related to continence care.

During observations on a day in October 2017, Inspector #577 observed resident #005 sitting up in their wheelchair. The Inspector spoke with PSW #102 who was the resident's assigned care provider. They reported that resident #005 was to be provided incontinence care after a meal and whenever required. They further reported that staff toileted resident #005 once a day.

During a staff interview on a day in October 2017, PSW #102 reported that resident #005 was toileted in the morning and were to be provided incontinence care in the evening. Inspector #577 and the PSW together reviewed resident #005's care plan which indicated that resident #005 was to be toileted at specific times. PSW #102 reported that the resident should be toileted as indicated by the care plan.

During a staff interview on a day in October 2017, RPN #104 reported that staff were to toilet the resident at specific times; staff were to provide incontinence care when they

were toileted and as needed. They further reported that the resident's care needs had not changed and they still required toileting at specific times.

On October 25, 2017, Inspector #577 spoke with the Director Of Care (DOC) who reported that staff should have been following resident #005's care plan interventions related to toileting. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During Stage one of the Inspection, resident #003 was identified as requiring further inspection related to continence.

Inspector #577 reviewed resident #003's care plan which indicated that the resident recently had a change in condition, needed specific assistance for toileting and required incontinence care.

During an interview with resident #003 on a day in October 2017, the resident was continent and told the Inspector that they didn't require incontinence care from staff and toileted themselves.

During an interview with PSW #122 on a day in October 2017, they reported that resident #003 was continent and toileted themselves.

Inspector #577 reviewed the home's policy titled "Care plans – NUR 110" last revised October 2014, which indicated that the care plan would reflect the resident's current strengths, abilities, preferences, needs, goals, safety/security risks and advance directives.

Inspector #577 spoke with the DOC on October 25, 2017, and they reported that resident #003 at one period of time, required incontinence care. They further confirmed that the resident was now continent and that their care plan was not updated to reflect their current needs. [s. 6. (10) (b)]

3. During Stage one of the Inspection, resident #008 was identified as having altered skin integrity and required further inspection.

Inspector #577 reviewed resident #008's care plan and found that the care plan did not contain any information related to skin integrity.

During a record review of resident #008's electronic health records, Inspector #577 found that the resident currently had an impaired skin area to a particular area of their body.

Inspector #577 reviewed the most current Resident Assessment Instrument-Minimum Data Set (RAI-MDS) dated September 2017, which indicated that resident #008 had impaired skin integrity.

The Inspector reviewed the home's policy titled "Care plans – NUR 110" last revised October 2014, which indicated that the staff would develop care plans for activities of daily living, nutritional and continence care and review care plans at least quarterly, and when there were significant changes to the residents' needs.

During an interview on a day in October 2017, RN #100 reported to the Inspector that resident #008 had impaired skin integrity to a particular area of their body.

On a day in October 2017, Inspector #577 spoke with RPN #123 who reported that resident #008 had impaired skin integrity to a particular area of their body and required daily treatment. They further confirmed that the resident's care plan did not contain any information related to skin impairment.

On a day in October 2017, Inspector #577 spoke with Resident Assessment Instrument (RAI) Coordinator #124 and reviewed the current care plan. They reported that the current care plan did not contain any information related to altered skin integrity and further confirmed that it was the responsibility of the Registered Nurses to update care plans.

On October 25, 2017, Inspector #577 spoke with the DOC who confirmed that resident #008 had impaired skin integrity and the resident's care plan was not updated to include information related to a skin impairment with interventions for care. They further reported that the Registered Nurse were responsible to update the care plans. [s. 6. (10) (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 the care set out in the plan of care is provided to the resident as specified in the plan; and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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 has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director in January 2017, which identified abuse resulting in injury. The CI report described abuse that had occurred in January 2017, and resulted with an injury to resident # 014, which was caused by resident # 012.

A review of the home's policy titled, "Zero Tolerance of Abuse and/or Neglect" last revised June 2015, identified that all staff, volunteers, contractors and affiliated personnel were required to immediately report any witnessed incident or alleged incident of abuse or neglect to the MOH-LTC. As well, to immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect. The Supervisor will then report the witnessed or alleged incident of abuse or neglect to the Director of Care and/or Administrator.

During an interview on October 25, 2017, with the DOC, they indicated that the RN in charge of the unit was expected to notify the DOC or Assistant Director of Care (manager on call for incidents outside of business hours) and confirmed that they had not been immediately notified of this incident by RN #117.

2. Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director in March 2017, which identified abuse resulting in injury. The CI report described abuse that had occurred in March 2017, and resulted with an injury to resident # 016 which was caused by resident # 012.

During an interview on October 25, 2017, with the DOC, they indicated that the RN in charge of the unit was expected to notify the DOC or ADOC and confirmed that they had not been immediately notified of this incident by RN #118. [s. 20. (1)]

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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

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 has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During Stage one of the Inspection, resident #008 was identified as having altered skin integrity and required further inspection.

A record review of the physician's orders indicated that resident #008 developed a skin impairment and treatments were ordered.

A review of resident #008's current RAI MDS identified that the resident had impaired skin integrity.

A review of the home's policy titled "Skin and Wound Care Program - NUR 035" last revised May 2017, indicated the following:

-for non-typical surgical/venous/arterial wounds, staff were to document a Goldcare wound note template PN-WA
-stage the pressure ulcer using the staging guidelines
-after a dressing change, complete the PUSH tool or PN-WA weekly including size (circumference and depth) of the wound, discharge from the wound, appearance, progression, pain, nutrition, equipment being used.

A review of the electronic health records over a four month period, revealed the Goldcare wound note templates PN-WA documented 7/19 or 36% of the time.

During an interview with RPN #123 and RN #125 on a day in October 2017, they both reported to Inspector #577 that staff were to document weekly on the PN-WA template on Goldcare.

During an interview with RAI Coordinator #124 on a day in October 2017, together with Inspector #577, reviewed the health care records for skin assessments and they reported that staff were to document weekly assessments. They confirmed that 12 out of 19 assessments were not conducted.

On October 26, 2017, Inspector #577 spoke with the DOC and together reviewed the electronic weekly skin assessments and they confirmed that the assessments should have been documented weekly, and were not. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

During Stage one of the Inspection, it was identified through a family interview, that resident #005 was observed to require incontinence care many times.

On a day in October 2017, Inspector #577 conducted a record review of resident #005's care plan and kardex which revealed nursing interventions related to incontinence care.

During observations on a day in October 2017, Inspector #577 observed resident #005 sitting up in their wheelchair. Inspector spoke with PSW #102 who was the resident's assigned care provider. They reported that resident #005 required staff to toilet the resident after a meal and provide resident #005 with incontinence care as needed. They further reported that staff toilet resident #005 once a day.

During a staff interview on a day in October 2017, PSW #102 reported that resident #005 was toileted at a certain time and required incontinence care in the evening.

During a staff interview on a day in October 2017, RPN #104 reported that resident #005 required staff to toilet the resident at specific times and provide incontinence care when they were toileted and as needed.

On October 25, 2017, Inspector #577 spoke with the DOC who reported that staff should have been toileting resident #005 according to the care plan interventions. [s. 51. (2) (c)]

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 each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, was easily seen, accessed and used by residents, staff and visitors at all times.

During Stage one of the inspection, it was identified that resident #020's bathroom call bell required further inspection related to it's accessibility.

On three days in October 2017, Inspectors #577 and #617 both observed the bathroom call bell cord in resident #020's shared bathroom located on the wall beside the toilet to be inaccessible while seated on the toilet. The call bell had a short metal pull chain approximately 7.5 centimeters long, and was located approximately 1.5 meters from the toilet, and was inaccessible for the resident to pull while seated on the toilet.

A review of resident #020's care plan indicated that they accessed the shared bathroom.

On a day in October 2017, Inspector #617 observed resident #020 use their shared bathroom.

In an interview with PSW #121, they reported that resident #020 did at times use the toilet in their shared bathroom and when they required assistance would call for help or come out to the hallway to get staff to assist them with incontinence care.

On a day in October 2017, during an interview with RPN #113, they attended resident #020's shared bathroom and confirmed that the call bell cord beside the toilet was too high for the resident to reach. [s. 17. (1) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term home were posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulation.

During the initial tour of the home, Inspector #613 was unable to locate copies of five inspection reports from the past two years for the long-term care home.

The missing inspection reports for the past two years were as follows:

During interviews on October 20, 2017, with the ADOC and DOC, they verified that the inspection reports for the past two years were not posted. [s. 79. (3) (k)]

Issued on this 13th day of December, 2017

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

Original report signed by the inspector.