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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 01, 2021	2020_740621_0020 (A3)	016758-20	Complaint

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 (Kenora)
1220 Valley Drive Kenora ON P9N 2W7

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

Amended by JULIE KUORIKOSKI (621) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension to compliance order #003 requested due to delay in course work and exam to qualify for CSNM. Extension granted to September 10, 2021.

Issued on this 1 st day of June, 2021 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JULIE KUORIKOSKI (621) - (A3)
Inspection No. / No de l'inspection :	2020_740621_0020 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	016758-20 (A3)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 01, 2021(A3)
Licensee / Titulaire de permis :	Board of Management of the District of Kenora 1220 Valley Drive, Kenora, ON, P9N-2W7
LTC Home / Foyer de SLD :	Pinecrest (Kenora) 1220 Valley Drive, Kenora, ON, P9N-2W7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kevin Queen

To Board of Management of the District of Kenora, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8. (1) of O. Reg. 79/10.

Specifically, the licensee must:

Part A

1) Ensure PSW's and Registered Nursing staff are compliant with the home's "Hydration" policy;

2) Provide training to all PSWs and Registered Nursing staff on intake monitoring and documentation procedures, for all residents, consistent with the home's policy by December 18, 2020. The home is to keep a record of who completed the training, the date of the training, who provided the training, and what the training entailed; and

3) Complete monthly audits intake monitoring and documentation for three identified residents, as well as a random selection of other residents at specific nutrition risk in the home, to ensure completeness of the record, accuracy of resident fluid intakes tabulations, and referral to the RN and/or RD when intakes less than goal. The home is to keep a record of all audits performed, along with any discrepancies found and actions taken.

Part B

1) Ensure PSW's and Registered Nursing staff are compliant with the home's "Weighing Residents" policy; and

2) Complete a monthly audit of three identified residents, and a random selection of residents at a specified nutrition risk in the home, to ensure weights are documented, and that appropriate follow up has been completed on particular weight changes identified. The home is to keep a record of all audits performed, along with any discrepancies found and actions taken.

Part C

1) Ensure Registered Nursing staff are compliant with the home's "Falls Prevention Program" policy; and

2) Complete an audit of two identified residents, and a random selection of residents at specified falls risk, to ensure falls risk assessments are conducted, with risk level identification documented in the resident's care plan, along with interventions appropriate to the resident's most current care needs. The home is to keep a record of all audits performed, along with any discrepancies found and actions taken.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee ensured that the policy was complied with.

In accordance with the Long-Term Care Homes Act (LTCHA),2007, s. 11 (1) (a), the licensee was required to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. Specifically, pursuant to O. Reg. 79/10, s. 68 (2) (d), the program was required to ensure a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration. Additionally, pursuant to O. Reg. 79/10, s. 30 (2), the licensee was required to ensure that any actions

taken with respect to a resident under the nutrition and hydration program, including recording of weights, were documented.

In accordance with O. Reg. 79/10, s. 48 (1) 1., the licensee was required to ensure that a falls prevention and management program to reduce the incidents of falls and risk of injury was developed and implemented. Specifically, pursuant to O. Reg. 79/10, s. 48 (2) (b), the program was required to ensure that in addition to meeting the requirements set out in section 30, the falls prevention and management program provided for assessment and reassessment instruments.

Specifically, staff did not comply with the home's policies.

a) A complaint was received by the Director regarding allegations of neglect of a resident.

A review of the resident's food and fluid intake records for specified months in 2020, found records incomplete. A review of the resident's care plan, identified the resident to be at a specified level of nutrition risk, with particular fluid intake goals calculated by the RD. During an interview with the RD, they identified that when they completed assessments of residents, they were unable to rely on data gathered from the daily food and fluid intake records, as the records were incomplete. The RD reported that this was a facility wide issue, and consequently, there was no consistency in fluid intake monitoring that the RD could rely upon for assessment purposes. Subsequent review of two additional residents identified the same missing documentation on the home's food and fluid intake records for the same specified months in 2020. Similarly, a review of both resident's care plans for specific dates in August and October 2020 respectively, found both to be assessed at a specified nutrition risk level.

A review of the home's policy, identified that all residents were to be provided a specified minimum amount of fluid, over a designated amount of time; that this fluid be offered at scheduled intervals, and any variations assessed by the RD and documented. Further the policy identified that all members of the multidisciplinary team were to monitor residents' hydration status as part of routine assessment, with any signs and symptoms of dehydration reported to the Registered Nurse (RN) and/or RD.

During an interview with a PSW, they reported that resident food and fluid records were to be completed in full by the PSWs primarily. They identified that food and fluid intake information for between meal nourishment times were not being documented. Further, they reported that PSWs were not completing any fluid calculations within a designated time frame, to see if residents were meeting minimum requirements. During an interview with an RPN, they reported that daily food and fluid intake records were completed by PSWs after meal service, checked by the RN at the end of the month, and monitored by the RD to determine if there is an issue or not. Subsequently, during an interview with another RPN, they reported that registered staff on the unit did not follow up on the food and fluid intake records completed by the PSWs, that fluid intake calculations were not done to determine if residents were meeting their daily fluid intake goals, and that intake records did not identify a legend to specify the fluid volumes of dining room glassware, or the residents fluid intake goals, as a comparator.

The ADOC reviewed fluid intake records with the Inspector, and confirmed that none were completed as required, and as a consequence, the staff were not following the home's hydration policy for monitoring residents to ensure that, residents received appropriate amounts of fluid daily to avoid complications.

Sources: "Hydration" policy, "Food and Nourishment Daily Records", care plans for identified residents, and RD nutrition assessment for a resident; interviews with the home's RD, a PSW, RPN's, the ADOC and other staff.

b) A complaint was received by the Director regarding allegations of lack of assessment of a resident.

During a review of the resident's assessment records, it was identified that the resident's weight change report for the previous year, had a missing recorded weight during a specified month in 2020. Additionally, a review weight records for two other residents found additional missing weights.

A review of the home's policy titled "Weighing Residents", it identified that PSWs recorded monthly weights at the time of the resident's first bath of the month, and recorded the weight on the Weight List, with registrants transferring the documented weight into the vitals section of the resident's electronic medical record (EMR). The policy identified that changes in weights were evaluated and action taken, as

required.

During an interview with an RPN, they confirmed the identified missing weights for the residents as identified by the Inspector, and verified that it was the RPNs responsibility to ensure that documented weights were accurate for all residents, were documented monthly in the EMR, and at any other time, as required by home's policy. During an interview with the ADOC, they reported that it was home's policy and their expectation that weights were taken and recorded into the resident's EMR at least once monthly, or more, if a re-weigh was required. Additionally, the ADOC confirmed that if there was no weight recorded in the EMR for a resident, then the home's weight monitoring policy was not followed.

Sources: "Weighting Residents" policy, 2019/2020 EMR "Weight Changes Report" for three residents, and Units 1 and 2 "Resident Weight Chart for 2020; interviews with an RPN, the ADOC and other staff.

c) A Critical Incident System (CIS) report was submitted to the Director on a date in July 2020, related to a fall of a resident, with injury.

On review of the resident's documented fall, as well as a specific number of earlier falls which occurred in June 2020, the Inspector was unable to locate a falls risk level on their care plan, or any other area of the resident's health care record.

On review of the home's policy active at that time of the incident, it identified that registered nursing staff were to conduct a falls risk assessment quarterly, according to the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) 2.0 schedule, or when a change in health status put them at increased falls risk, such as two falls in 72 hours, a significant change in health status, or falls that resulted in serious injury. Additionally, the policy identified that the registered nursing staff were to determine the resident's level of risk as "Low or High", and any risk should be care planned.

During an interview with the RAI Coordinator, they reported that falls risk assessments were completed by the RAI Coordinator as part of admission and quarterly RAI-MDS assessments, but were not done as per policy, when a change in health status put the resident at increased falls risk. The RAI Coordinator confirmed registered nursing staff were not completing the risk assessments, and falls risk scores were not being documented on the resident's care plan. When the Inspector

inquired as to other residents at a specified falls risk, most recent falls care plans were reviewed and found to also have no falls risk score listed.

The ADOC confirmed that the home did not have a falls risk assessment tool completed by registered nursing staff, other than what scoring was completed within the RAI-MDS system by the RAI Coordinator, and consequently, there was a gap in documentation, which resulted in the home's falls program policy not being followed.

Sources: The home's Falls Prevention Program policy; interviews with the RAI Coordinator, the ADOC and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to three residents with respect to incomplete fluid intake records to support hydration monitoring and assessment; there was actual risk of harm to three residents with respect to incomplete weight records to support regular weight monitoring and assessment; and there was actual risk of harm to one resident, with respect to lack of falls risk assessment.

Scope: The scope of this non-compliance was wide spread, with nine out of nine (100%) of residents inspected found to have incomplete fluid, weight and/or falls risk assessments records, as per home's policies.

Compliance History: The licensee was found to be non-compliant with different sections of the legislation within the past 36 months. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 07, 2021(A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

The licensee must comply with s. 30 (1) 3 of O. Reg. 79/10.

Additionally, the licensee must:

Prepare, submit and implement a plan to ensure that the home's entire nutrition care and dietary services program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. The plan must include, but is not limited to, the following:

a) How the licensee will ensure the nutrition care and dietary services program are evaluated and updated at least annually, and how documentation of this review will be maintained;

b) How the licensee will ensure that the program is specific to the home and meets the requirements identified in the Ontario Regulation 79/10, s. 68 - s. 74;

c) How the licensee will ensure that the dietary services component of the nutrition care and dietary services program includes menu planning; food production; dining and snack service; and availability of supplies and equipment for food production and dining and snack service; and

d) How the licensee will ensure that the home's registered dietitian participates in the annual review of the nutrition care and dietary services program and how this participation will be documented.

Please submit the written plan, quoting Inspection #2020_740621_0020 and Inspector, Julie Kuorikoski, by email to SudburySAO.moh@ontario.ca by December 18, 2020.

Please ensure that the submitted written plan does not contain any Personal Information and/or Personal Health Information.

Grounds / Motifs :

1. The licensee has failed to ensure that the nutrition, dietary services and hydration program under section 11 of the Act, was evaluated at least annually in accordance

with evidence-based practices, and if there were none, in accordance with prevailing practices.

A complaint was submitted to the Director, regarding nutrition and hydration care of a resident.

During a review of the home's hydration program policy titled "Hydration – DTY 250", the Inspector identified that the last date of revision of the policy was October 2015.

On request of the Inspector, the ADOC, provided additional nutrition, dietary services and hydration program policies, including the following:
- "Daily Intake Record – DTY 285", last updated October 2015;
- "Goals and Objectives – DTY 010", last updated October 2015;
- "Nutrition Assessment and Risk Identifications – DTY 290", last updated August 2017;
- "Pleasant Dining with Dignity – DTY 135", last updated October 2015; and
- "Menu Planning – DTY 210", last updated October 2015.

During an interview with the Administrator, they reported that in reference to the nutrition, dietary services and hydration program policies and procedures, that review and evaluation of them had been intermittent and sporadic. They confirmed that a review had not been completed in the past several years for many policies, and some not updated in keeping with the change in the long-term care legislation. The Administrator admitted that more work needed to be done in this area.

Sources: Nutrition, dietary services and hydration program policies and procedures (DTY 250, 285, 010, 290, 135 and 210); interviews with the Administrator and staff.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to residents.

Scope: The scope of this non-compliance was wide spread, with six out of seven (86%) of nutrition, dietary and hydration policies found with revision dates of greater than one year past due.

Compliance History: One voluntary plan of correction (VPC) was issued to the home

related to s. 30 (1) 3 in the past 36 months. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10,
s. 75. (2) A person hired as a nutrition manager after the coming into force of this section must be an active member of the Canadian Society of Nutrition Management or a registered dietitian. O. Reg. 79/10, s. 75 (2).

Order / Ordre :

The licensee must be compliant with s. 75 (2) of Ontario Regulation (O. Reg.) 79/10.

Additionally, the licensee must:

Maintain record of the Nutrition Manager's annual active membership within the CSNM at all times.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that the person hired as nutrition manager (NM), was an active member of the Canadian Society of Nutrition Management (CSNM), or a registered dietitian (RD).

A complaint was submitted to the Director related to nutrition and hydration care concerns for a resident.

During an interview with the home's RD, it was reported that the home's previous NM had retired at the beginning of 2020, and the incumbent's was in process of completing course work to qualify for active membership with the CSNM. During further interviews with the current NM and the Administrator, it was confirmed that the NM was completing course work, in order to qualify to write and pass the CSNM exam and currently held only student membership with CSNM. At the time of inspection, the current NM was neither a full active member of CSNM, nor an RD, as per legislative requirements.

Sources: RD, the NM, and Administrator interviews; letter of student membership with CSNM, and letter of admission to Bow Valley College Nutrition Manager Certificate program.

An order was made by taking the following factors into account:

Severity: There was minimal harm as there had not been any incidents related to the NM qualifications since last inspection.

Scope: The scope of this non-compliance was wide spread, because it affected nutrition and dietary service activities of all residents in the home.

Compliance History: The licensee was found to be non-compliant with different sections of the legislation within the previous 36 months. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 10, 2021(A3)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Ontario

Ministry of Long-Term Care

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Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 1 st day of June, 2021 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JULIE KUORIKOSKI (621) - (A3)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Service Area Office / Bureau régional de services : Sudbury Service Area Office

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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 01, 2021	2020_740621_0020 (A3)	016758-20	Complaint

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 (Kenora)
1220 Valley Drive Kenora ON P9N 2W7

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

Amended by JULIE KUORIKOSKI (621) - (A3)

Amended 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): October 19 - 23, and 26 - 29, 2020.

The following intake was inspected upon during this Complaint inspection:

- One intake, related to alleged staff-to-resident neglect.

Critical Incident System (CIS) inspection #2020_740621_0021 was conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Registered Dietitian (RD), the Nutrition Manager (NM), and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff-to-resident interactions, reviewed relevant resident health care records, as well as applicable policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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

4 WN(s)
0 VPC(s)
3 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 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 where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee ensured that the policy was complied with.

In accordance with the Long-Term Care Homes Act (LTCHA),2007, s. 11 (1) (a), the licensee was required to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. Specifically, pursuant to O. Reg. 79/10, s. 68 (2) (d), the program was required to ensure a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration. Additionally, pursuant to O. Reg. 79/10, s. 30 (2), the licensee was required to ensure that any actions taken with respect to a resident under the nutrition and hydration program, including recording of weights, were documented.

In accordance with O. Reg. 79/10, s. 48 (1) 1., the licensee was required to ensure that a falls prevention and management program to reduce the incidents of falls and risk of injury was developed and implemented. Specifically, pursuant to O. Reg. 79/10, s. 48 (2) (b), the program was required to ensure that in addition to meeting the requirements set out in section 30, the falls prevention and management program provided for assessment and reassessment instruments.

Specifically, staff did not comply with the home’s policies.

a) A complaint was received by the Director regarding allegations of neglect of a resident.

A review of the resident's food and fluid intake records for specified months in

2020, found records incomplete. A review of the resident's care plan, identified the resident to be at a specified level of nutrition risk, with particular fluid intake goals calculated by the RD. During an interview with the RD, they identified that when they completed assessments of residents, they were unable to rely on data gathered from the daily food and fluid intake records, as the records were incomplete. The RD reported that this was a facility wide issue, and consequently, there was no consistency in fluid intake monitoring that the RD could rely upon for assessment purposes. Subsequent review of two additional residents identified the same missing documentation on the home's food and fluid intake records for the same specified months in 2020. Similarly, a review of both resident's care plans for specific dates in August and October 2020 respectively, found both to be assessed at a specified nutrition risk level.

A review of the home's policy, identified that all residents were to be provided a specified minimum amount of fluid, over a designated amount of time; that this fluid be offered at scheduled intervals, and any variations assessed by the RD and documented. Further the policy identified that all members of the multidisciplinary team were to monitor residents' hydration status as part of routine assessment, with any signs and symptoms of dehydration reported to the Registered Nurse (RN) and/or RD.

During an interview with a PSW, they reported that resident food and fluid records were to be completed in full by the PSWs primarily. They identified that food and fluid intake information for between meal nourishment times were not being documented. Further, they reported that PSWs were not completing any fluid calculations within a designated time frame, to see if residents were meeting minimum requirements. During an interview with an RPN, they reported that daily food and fluid intake records were completed by PSWs after meal service, checked by the RN at the end of the month, and monitored by the RD to determine if there is an issue or not. Subsequently, during an interview with another RPN, they reported that registered staff on the unit did not follow up on the food and fluid intake records completed by the PSWs, that fluid intake calculations were not done to determine if residents were meeting their daily fluid intake goals, and that intake records did not identify a legend to specify the fluid volumes of dining room glassware, or the residents fluid intake goals, as a comparator.

The ADOC reviewed fluid intake records with the Inspector, and confirmed that none were completed as required, and as a consequence, the staff were not

following the home's hydration policy for monitoring residents to ensure that, residents received appropriate amounts of fluid daily to avoid complications.

Sources: "Hydration" policy, "Food and Nourishment Daily Records", care plans for identified residents, and RD nutrition assessment for a resident; interviews with the home's RD, a PSW, RPN's, the ADOC and other staff.

b) A complaint was received by the Director regarding allegations of lack of assessment of a resident.

During a review of the resident's assessment records, it was identified that the resident's weight change report for the previous year, had a missing recorded weight during a specified month in 2020. Additionally, a review weight records for two other residents found additional missing weights.

A review of the home's policy titled "Weighing Residents", it identified that PSWs recorded monthly weights at the time of the resident's first bath of the month, and recorded the weight on the Weight List, with registrants transferring the documented weight into the vitals section of the resident's electronic medical record (EMR). The policy identified that changes in weights were evaluated and action taken, as required.

During an interview with an RPN, they confirmed the identified missing weights for the residents as identified by the Inspector, and verified that it was the RPNs responsibility to ensure that documented weights were accurate for all residents, were documented monthly in the EMR, and at any other time, as required by home's policy. During an interview with the ADOC, they reported that it was home's policy and their expectation that weights were taken and recorded into the resident's EMR at least once monthly, or more, if a re-weigh was required. Additionally, the ADOC confirmed that if there was no weight recorded in the EMR for a resident, then the home's weight monitoring policy was not followed.

Sources: "Weighting Residents" policy, 2019/2020 EMR "Weight Changes Report" for three residents, and Units 1 and 2 "Resident Weight Chart for 2020; interviews with an RPN, the ADOC and other staff.

c) A Critical Incident System (CIS) report was submitted to the Director on a date in July 2020, related to a fall of a resident, with injury.

On review of the resident's documented fall, as well as a specific number of earlier falls which occurred in June 2020, the Inspector was unable to locate a falls risk level on their care plan, or any other area of the resident's health care record.

On review of the home's policy active at that time of the incident, it identified that registered nursing staff were to conduct a falls risk assessment quarterly, according to the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) 2.0 schedule, or when a change in health status put them at increased falls risk, such as two falls in 72 hours, a significant change in health status, or falls that resulted in serious injury. Additionally, the policy identified that the registered nursing staff were to determine the resident's level of risk as "Low or High", and any risk should be care planned.

During an interview with the RAI Coordinator, they reported that falls risk assessments were completed by the RAI Coordinator as part of admission and quarterly RAI-MDS assessments, but were not done as per policy, when a change in health status put the resident at increased falls risk. The RAI Coordinator confirmed registered nursing staff were not completing the risk assessments, and falls risk scores were not being documented on the resident's care plan. When the Inspector inquired as to other residents at a specified falls risk, most recent falls care plans were reviewed and found to also have no falls risk score listed.

The ADOC confirmed that the home did not have a falls risk assessment tool completed by registered nursing staff, other than what scoring was completed within the RAI-MDS system by the RAI Coordinator, and consequently, there was a gap in documentation, which resulted in the home's falls program policy not being followed.

Sources: The home's Falls Prevention Program policy; interviews with the RAI Coordinator, the ADOC and other staff. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition, dietary services and hydration program under section 11 of the Act, was evaluated at least annually in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices.

A complaint was submitted to the Director, regarding nutrition and hydration care of a resident.

During a review of the home's hydration program policy titled "Hydration – DTY 250", the Inspector identified that the last date of revision of the policy was October 2015.

On request of the Inspector, the ADOC, provided additional nutrition, dietary services and hydration program policies, including the following:
- "Daily Intake Record – DTY 285", last updated October 2015;
- "Goals and Objectives – DTY 010", last updated October 2015;
- "Nutrition Assessment and Risk Identifications – DTY 290", last updated August 2017;
- "Pleasant Dining with Dignity – DTY 135", last updated October 2015; and
- "Menu Planning – DTY 210", last updated October 2015.

During an interview with the Administrator, they reported that in reference to the nutrition, dietary services and hydration program policies and procedures, that review and evaluation of them had been intermittent and sporadic. They confirmed that a review had not been completed in the past several years for many policies, and some not updated in keeping with the change in the long-term care legislation. The Administrator admitted that more work needed to be done in this area.

Sources: Nutrition, dietary services and hydration program policies and procedures (DTY 250, 285, 010, 290, 135 and 210); interviews with the Administrator and staff. [s. 30. (1) 3.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (2) A person hired as a nutrition manager after the coming into force of this section must be an active member of the Canadian Society of Nutrition Management or a registered dietitian. O. Reg. 79/10, s. 75 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person hired as nutrition manager (NM), was an active member of the Canadian Society of Nutrition Management (CSNM), or a registered dietitian (RD).

A complaint was submitted to the Director related to nutrition and hydration care concerns of a resident.

During an interview with the home's RD, it was reported that the home's previous NM had retired at the beginning of 2020, and the incumbent's was in process of completing course work to qualify for active membership with the CSNM. During further interviews with the current NM and the Administrator, it was confirmed that the NM was completing course work, in order to qualify to write and pass the CSNM exam and currently held only student membership with CSNM. At the time of inspection, the current NM was neither a full active member of CSNM, nor an RD, as per legislative requirements.

Sources: RD, the NM, and Administrator interviews; letter of student membership with CSNM, and letter of admission to Bow Valley College Nutrition Manager Certificate program. [s. 75. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

A complaint submitted to the Director, identified concerns related to a specific resident's personal care.

During a review of the resident's care plan, with a specific focus, it identified that the resident was to be provided a certain type of bath care at scheduled intervals, a certain number of times a week.

A review of bath records titled "Bathing Records and Assessment", for a specified number of dates in August 2020, found records for the resident incomplete in specific areas of the record.

During interviews with a PSW and RPN, they identified that the "Bathing Record and Assessment" form, was the resident's bath record, and that it was to be completed in full by the PSW after each bathing event. An RPN reviewed the resident's bath records with the Inspector, for specified dates in August 2020, and confirmed with the Inspector that the records were incomplete, and therefore at the time of inspection, were found not up-to-date at all times.

Sources: interview with a PSW, an RPN and other staff; a record review including the specific resident's care plan and "Bathing Record and Assessment" form for specified dates in 2020 [s. 231. (b)]

Issued on this 1 st day of June, 2021 (A3)

[redacted]

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

Original report signed by the inspector.