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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 30, 2015	2015_291552_0020	O-002373-15	Resident Quality Inspection

Licensee/Titulaire de permis

MEDLAW CORPORATION LIMITED
42 Elgin Street Thornhill ON L3T 1W4

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

PINECREST NURSING HOME (2731)
3418 County Road 36 R.R. #2 BOBCAYGEON ON K0M 1A0

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

MARIA FRANCIS-ALLEN (552), CHANTAL LAFRENIERE (194), KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 10-14 & 17-19, 2015

Complaint log # O-005959-15 was also inspected

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), RAI-Coordinator, Personal Support Workers (PSW), Dietary Manager, Maintenance Worker, Laundry aide, family and residents

Also toured the home, observed dining service, medication administration, infection control practices, staff to resident interaction during provision of care. Reviewed clinical health records, relevant policies - Minimizing of Restraints, Medication Administration, Falls Prevention, Responsive Behaviours, Continence and Bowel Management Program

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

6 WN(s)
3 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 15(2)a, ensuring that the home, furnishings and equipment are kept clean and sanitary.

On August 10, 2015 during the initial tour of the building it was noted the upholstery on many chairs in the lounge area were soiled and stained.

During an interview Administrator indicated she was aware of the situation and the chairs will be replaced in the near future. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA s. 15(2)c, ensuring that furnishings and equipment are maintained in a safe condition and in a good state of repair

On August 11, 2015 during room observations it was noted by Inspectors #194 and #552 that the windows in three rooms could not be latched in the closed position properly, once opened.

On August 11, 2015 during room observations it was noted by Inspector #552 that in a shared bedroom, there was no crank available for the windows..

On August 11, 2015 during observation of a specific room it was noted the elevated toilet seat and grab bars were very loose. This could be a potential fall risk for the residents using the equipment. [s. 15. (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 the home, furnishing and equipment are kept clean, sanitary and maintained in a safe condition and good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the program provide for assessment and reassessment instruments.

Log #O-001947-15

Resident #041 was admitted to the home on an identified date and discharged several months later. During the admission period Resident #041 had 11 falls, with no serious injury.

Review of the Resident #041's clinical health records indicate that on an identified date the resident had 2 falls, and then had 3 falls two months later. No falls assessment was completed for the resident using a clinically appropriate assessment instrument that is specifically designed for falls.

During an interview, the DOC indicated the home does not have a clinically appropriate assessment instrument that is specifically designed for falls.

During an interview both the DOC and Administrator have indicated the Falls Program is being reviewed and a clinically appropriate falls assessment instrument that is specifically designed for falls is being implemented at the home. DOC and Administrator have indicated the falls assessment tool would be utilized when a resident is admitted, quarterly, with if a significant change in condition or if a resident has had 2 or more falls in a one month period. [s. 48. (2) (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 falls program must provide for assessment and reassessment instruments, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the physical device was applied in accordance with the manufacturer's instructions.

Resident #004 was observed by Inspector #601 on August 13, 2015, with a back fastening seat belt having a space greater than three finger widths between the seat belt and the front of Resident #004's waist.
Resident #004 current care plan identified the resident is cognitively impaired, with a history of falls related to unpredictable weight bearing, and is able to take the seat belt off. Review of the clinical health records indicate the resident was at risk for falls and the resident's spouse had requested the resident use a seat belt because the resident would try to get up by his/herself. [s. 110. (1) 1.]

Regarding Resident #007

Resident #007 was observed by Inspector #601 and the DOC on August 18, 2015, with a front closure seat belt having a space greater than three fingers width between the seat

belt and the resident's waist.
The resident's clinical health records indicate the resident is at risk for falls related to involuntary movements. Review of the current care plan directs staff to ensure the seat belt is in place when the resident is in the wheelchair and the seat belt is used as a restraint. [s. 110. (1) 1.]

Regarding Resident #022

Resident #022 was observed by Inspector #601 on August 11, 2015 with a back fastening seat belt having a space greater than three finger width between the seat belt and the front of the resident's waist.

Review of the clinical health records identified the resident is at risk for falls related to attempts to get out of the chair.
The current care plan directs the staff to ensure the back fastening seat belt restraint is in place when the resident is seated in the wheelchair. [s. 110. (1) 1.]

Regarding Resident #031

Resident #031 was observed by the DOC and Inspector #601 on August 18, 2015 with a back fastening seat belt having a space greater than three finger widths between the seat belt and the resident's waist.
Resident #031's current care plan identified the resident as being cognitively impaired and was not identified as a fall risk.
Review of the clinical health records indicate, the seat belt was ordered as a restraint as the resident forgets he/she is no longer able to walk on his/her own. [s. 110. (1) 1.]

Regarding Resident #039

Resident #039 was observed by Inspector #552 and #601 on August 11 & 18, 2015 with a back fastening seat belt having a space greater than three finger widths between the seat belt and the Resident's waist.
Resident #039's current care plan identified the resident is cognitively impaired and is at risk for falls related to cognitive impaired with impaired mobility. Review of the physician's orders indicate seat belt restraint was ordered. [s. 110. (1) 1.]

Regarding Resident #043

Resident #043 was observed by the DOC and Inspector #601 on August 18, 2015 with a back fastening seat belt which was observed to have a space greater than three fingers between the seat belt and the front of resident's waist. The clinical health records indicated the resident is cognitively impaired with a history of falls. Review of the care plan directs staff to ensure the seat belt is in place when the resident is up in the wheelchair and that staff are to follow the policy and procedure for restraints. [s. 110. (1) 1.]

Review of the Policy "Minimizing of Restraints" (last revised January 16, 2015) directs:
-Staff must apply the physical device in accordance with any manufacturer's instructions.
During an interview, the DOC indicated the home identified the Vendors documentation for "Use & Care of Wheelchair Hip Belts", as the manufacturer's instructions.

Review of the manufacturer's instructions "Use & Care of Wheelchair Hip Belts" directs:
General Use Instructions
-Common practice is to allow just enough space for two fingers to fit between the hip belt and the person's body, at any one point along the belt.
Adjustments
-Care staff should tighten a hip belt by pulling the adjustment strap, at the buckle, until all slack is removed (i.e. just enough space for two fingers to fit between the belt and the person's body). This should leave a "tail" of adjustment strap about 3" or less.

During an interview with the Administrator and DOC, both agreed Residents #004, 007, 022, 031,039 and 043 seat belts were not applied according to the manufacturer's instructions and that the staff members require better direction to ensure the seat belts are safely applied around the resident's hip with no more than two or three width between seat belt and resident's body. [s. 110. (1) 1.]

2. The licensee has failed to ensure the physical device is not altered except for routine adjustments in accordance with the manufacturer's instructions.

Resident #004 was observed by Inspector #601 on August 13, 2015 with a seat belt strap tied in a knot securing the seat belt to the wheelchair frame at the back, on the lower right side.

Resident #022 was observed by Inspector #601 on August 11, 2015, with a back fastening seat belt in place that was not secured to the wheelchair. During an interview

on August 12, 2015, the Administrator indicated that Resident #022's seat belt that was in place on August 11, 2015 was for a bath chair, and was not appropriate for wheelchair use.

Residents #031 and #039 was observed by the DOC and Inspector #601 on August 18, 2015 with a back fastening seat belt, the seat belt strap was secured to the wheelchair frame at the back using a zip tie on the bottom, left side of the wheelchair.

Review of the Policy "Minimizing of Restraints" directs:

-Staff must apply the physical device in accordance with any manufacturer's instructions.
-The physical device may not be altered except for routine adjustments in accordance with any manufacturer's instructions.

Review of the manufacturer's instructions "Use & Care of Wheelchair Hip Belts" directs: The use of any wheelchair and/or seating components should be based on individual's needs, as determined by qualified care staff or therapist. Any equipment set-up, adjustments or repairs should only be completed by trained personnel or technician.

During an interview on August 18, 2015, the DOC and Administrator indicated the maintenance worker has always applied the seat belts to the wheelchairs, as requested by the registered staff. The DOC indicated they were unaware who applied the bath seat belt to Resident #022 wheelchair. It was also identified the Maintenance worker determined the zip ties caused less fraying then the bolts that were previously used to secure the seat belts to the frame of the wheelchair. The DOC and the Administrator were not aware of the maintenance worker having any specific qualifications to make adjustments to the seat belts, or repairs to the wheelchairs as per manufacturer's instructions. [s. 110. (1) 3.]

3. The licensee has failed to ensure that staff do not apply physical devices that have not been ordered or approved by a physician or registered nurse in the extended class.

Resident #031 was observed by the DOC and Inspector #601 on August 18, 2015 with a back fastening seat belt in place.
Plan of care reviewed, and Resident #031 does not have a current Physician order for a back fastening seat belt restraint.

Resident #031's current care plan identified the resident is cognitively impaired and did

not indicate the resident was at risk for falls.

During an interview on August 18, 2015, PSW #115 indicated Resident #031's seat belt restraint was applied following morning care, and was not aware the order for the seat belt restraint had been discontinued by the Physician.

During an interview, the DOC indicated that Resident #031 no longer required a seat belt restraint, and the Physician's order to discontinue the restraint was obtained on August 6, 2015. [s. 110. (2) 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 staff apply the physical device in accordance with any manufacturer's instructions; that the device is not altered except for routine adjustments in accordance with any manufacturer's instructions and that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the SDM for Resident #041 had been provided the opportunity to participate fully in the development and implementation of the plan of care related to mobility and ambulation needs.

Related to log # O-005959-15

A complaint log was received regarding Resident #041 related to the rapid decline in the resident's ambulation and mobility.

Review of the clinical health record indicates multiple lift and transfer assessments were completed, there were changes in mobility aids, and the resident had numerous falls during whilst in the home. Review of progress notes was completed and there was no evidence of POA being informed of lift/transfer assessment being completed or resulting changes in the resident's need for mobility aids. Clinical health records indicate 11 falls during the admission of the resident with the POA being informed of only two incidents.

During an interview with the resident's family, they indicated they were not informed about the resident's decline in condition as it related to the ambulation and use of mobility aids.

During an interview the DOC indicated the staff may have become confused who to contact related to care needs for Resident #041 after the financial POA had been changed to PGT. DOC has confirmed that no changes to POA for care had been made during the resident's admission to the home. [s. 6. (5)]

WN #5: 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 Resident #009 exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff.

Resident #009 was observed by inspector #194 on August 12, 2015 with altered skin integrity. Resident #009 was not able to identify the cause of the altered skin integrity and denied any discomfort.

During interview on August 14, 2015 PSW #105 indicated that she was not aware the resident exhibited altered skin integrity.

During interview on August 17, 2105 RN #111 indicated that she was not aware the resident had altered skin integrity. RN #111 and Inspector #194 observed Resident #009's and the skin appeared worse than initially observed by the inspector.

Review of the clinical health record indicated the last documentation regarding the resident's skin integrity was on December 11, 2014. No current skin assessment was found. [s. 50. (2) (b) (i)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On August 18, 2015 the locked medication room and the unlocked fridge was observed. The fridge had a locked gray box which stored 10 vials of injectable controlled substances.

During an interview on August 18, 2015, RPN #112 indicated there were 10 vials of injectable controlled substances stored in a locked gray box in the fridge along with other medications that require refrigerator. RPN # 112 further indicated only the registered staff have the key for the medication room.

During an interview with the DOC, it was confirmed the controlled substance was being stored in the unlocked fridge and arrangements will be made to ensure the controlled substance is stored in a separate, double locked stationary fridge.

On August 19, 2015 the fridge in the medication room was observed locked. During an interview with the RPN # 112 and DOC, both confirmed the fridge is now locked and the registered staff responsible for administering medications is the only individual who has the key for the fridge. [s. 129. (1) (b)]

Issued on this 17th day of November, 2015

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

Original report signed by the inspector.