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
Jan 9, 2018	2017_621547_0021	014841-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON N3H 5L8

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

PINECREST NURSING HOME (2797)
101 PARENT STREET P.O. BOX250 PLANTAGENET ON K0B 1L0

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

LISA KLUKE (547), LINDA HARKINS (126)

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): December 27,28,29, 2017 and January 2,3,4,5, 2018

Complaint inspection log #009325-17 related to care provided to a resident, was completed concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/ Director of Care (DOC), a Charge Registered Nurse, the Resident Assessment Instrument (RAI) Coordinator, the Activity Director, the Maintenance Supervisor, the Nutritional Manager (NM), a Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeepers, the president of Resident's Council, a Member of the Family Council, residents and family members.

In addition the inspection team reviewed resident health care records, Resident and Family Council's minutes, policies related to Prevention of Abuse, Infection Prevention and Control, mobility equipment cleaning schedules and specified medication incident reports. The inspectors observed the delivery of resident care and services and staff to resident as well as resident to resident interactions, along with a review of medication administrations and storage areas.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care related to sleep and rest routines set out in the plan of care, was provided to resident #011 as specified in the plan.

On December 28, 2017 resident #011 indicated to inspector #547 that staff got the resident up too early in the morning, and preferred to not get up until a specified time identified in the resident's plan of care. Resident #011 indicated that over the last few months, the Personal Support Workers(PSW)'s told the resident that they had to get the resident up earlier in the morning due to their work schedules before breakfast.

On January 2, 2018 the resident further indicated to Inspector #547 that the PSW's continue to get the resident up early and that morning they had woke the resident up at an earlier specified time.

Inspector #547 reviewed resident #011's current plan of care, which documented the resident's sleep and rest patterns preferences to get up in the morning at a specified time of day.

On January 4, 2018 the Resident Assessment Instrument (RAI) Coordinator indicated to Inspector #547 that all residents discuss with the home their sleep and rest routine preferences if they have any, and this is added to the resident's plan of care at admission. These times identified in the residents plans of care would only be changed if the residents requested a change in time or the residents approved a new suggested time.

On January 4, 2018 PSW #102 indicated to Inspector #547 that she was caring for the resident, and that she tried to wait until later that morning to wake the resident, as she was aware the resident preferred to sleep in. PSW #102 indicated that she woke the resident at approximately a specified time that morning, 40 minutes earlier than specified in the resident's plan of care. PSW #102 indicated that she was aware the resident's careplan specified to not wake the resident until a specified time, however due to workload in the resident's wing, the PSW staff have been getting the resident up earlier, in order to not be late for breakfast at 0800 hours.

The Administrator/DOC indicated to Inspector #547 that she was not aware of this workload concern by the PSW's and that resident's preferences had to be followed as identified in their plans of care. [s. 6. (7)]

WN #2: 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 has failed to ensure that the residents mobility equipment were kept clean and sanitary.

On Thursday December 28, 2017, Tuesday January 2nd and Wednesday January 3, 2018, Inspector #547 observed resident #011, #012 and #016's mobility equipment to be heavily soiled with dried food matter, dust and debris. Resident #016's mobility equipment was also noted on these dates to have an offensive odour.

On Wednesday, January 3, 2018 Inspector #547 reviewed the home's Resident Mobility Equipment Cleaning schedule and noted that residents #011,#012 and #016 were due to have their mobility equipment cleaned on specified days each week.

On January 3, 2018 Inspector #547 interviewed RN #117 who indicated that he usually worked nights in the home and that mobility equipment is washed according to the home's Mobility Equipment Cleaning schedule and as required. RN #117 indicated PSW's are required to wash mobility devices if they note walkers or wheelchairs to be soiled or have odours. RN #117 observed resident #012's mobility equipment with the same dried food matter, dust and debris Inspector #547 had noted since December 28, 2017 and indicated that the resident's mobility equipment was soiled and required cleaning. RN #117 indicated that he was surprised as mobility equipment is usually washed according to their schedule and this is followed during the night shift in the home. Resident #025 was using mobility equipment next to where we were standing during this interview, and further observed this resident's mobility equipment was heavily soiled with dried food matter, dust and debris. RN #117 indicated that he would report this on the 24 hour shift report, to ensure communication is done to the next two shifts, and closer attention will be required to the cleaning of mobility equipment schedule on all shifts.

On January 3, 2018 the Administrator/DOC indicated to Inspector #547 that she developed this cleaning schedule for the home to ensure that resident's mobility equipment are cleaned weekly and as required. These mobility devices will need to be assessed today and follow-up with nursing staff to ensure that registered nursing staff are monitoring the implementation of this schedule. [s. 15. (2) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to resident #016 under the skin and wound program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

On December 28, 2017 and January 3, 2018 inspector #547 observed resident #016's to have a specified area with altered skin integrity.

On January 3, 2018 Inspector #547 reviewed resident #016's health care records. Resident #016 was admitted to the home on a specified date with several medical diagnoses. Resident's current plan of care related to skin and positioning with a specified mobility device identified the resident required specified interventions for positioning while utilizing this specified mobility device as required. Resident #016 is known to have positioning issues while utilizing this specified mobility device and requires complete staff assistance for mobility related to limited range in motion, reduced strength and poor coordination related to dementia. Resident #016's plan of care further identified the resident is at risk of impaired skin integrity due to reduced mobility and fragility of skin. A progress note on a specified date by RN #108 indicated that the resident presented with an area of altered skin integrity from unknown cause.

RN #100 indicated to Inspector #547 on December 28, 2017 during my observation of the resident, that the resident altered his/her skin integrity with a specified action while utilizing a specified mobility device.

PSWs #109, 110 and #121 indicated to Inspector #547 on January 3, 2018 that they are the regular day shift staff for the resident at this time. The PSW's indicated that the resident is not known to do this specified action against the resident's mobility device and indicated that the resident does have positioning concerns however these would not be enough to cause this altered skin integrity.

PSWs #118, #119 and #120 indicated to Inspector #547 on January 3, 2017 that they are the regular evening shift staff for the resident at this time. The PSW's indicated they did not know how the resident could have altered the skin integrity to this specified area and that they had never seen the resident do this specified action while utilizing this specified mobility device that could cause this type of alteration of skin integrity.

RN #108 indicated to Inspector #547 on January 4, 2018 that he provided the resident's medications around a specified time in the evening of a specified date while the resident was seated in the lounge of the home and had not noticed any altered skin to the specified area on the resident at that time. The resident sits within his view for the supper meal, and he did not see anything that could have caused the resident to altered the skin to this specified body part. RN #108 indicated that he recalled noticing the alteration of skin integrity on the resident during the supper meal on a specified date. RN #108 further indicated that he has not seen the resident position or do the specified action identified before, however no staff were able to recall how this alteration of skin integrity could have happened, and assumed that is how it may have happened. RN #108 indicated that he did not have time to complete a skin assessment for the resident, but that he wrote a progress note in the resident's health care records. RN #108 further indicated that he did not reassess the resident's plan of care to prevent further incidents causing this type of alteration of skin integrity.

Staff are to complete weekly skin assessment for all skin issues until resolved. No skin assessments were documented in the resident's health records for this specified altered skin integrity area. Over the course of this inspection that began December 27, 2017, Inspector #547 has not observed the resident with any positioning issues or do this specified action while utilizing this specified mobility device.

The home's skin and wound care program identified all skin impairment require staff to document on a Skin and Wound Observation and Communication form #RC-06-12-01 A9. This form requires registered nursing staff to assess the resident's altered skin integrity to include measurement of the affected area, provide treatment as required to the resident, complete a weekly impaired skin integrity, and to indicate this altered skin integrity to the resident's plan of care and interventions required.

As such, the Licensee failed to ensure these actions were completed and documented with respect to resident #016 under the skin and wound program related to this altered skin integrity to the specified body part on this specified date. [s. 30. (2)]

Issued on this 9th day of January, 2018

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

Original report signed by the inspector.