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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 28, 2016	2016_512196_0013	010464-16, 015612-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

PINEWOOD COURT
2625 WALSH STREET EAST THUNDER BAY ON P7E 2E5

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

LAUREN TENHUNEN (196), KATHERINE BARCA (625)

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): August 15, 16, 17, 18, 19, 22, 2016.

The following intakes were inspected: two intakes related to resident care concerns.

During the course of the inspection, the Inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions and the provision of care and services to residents, reviewed submitted Infoline complaint reports and reviewed several resident health care records.

This Complaint inspection was conducted concurrently with a Critical Incident System inspection #2016_512196_0014 and a Follow up inspection #2016_512196_0012.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Manager (FSM), Resident Assessment Instrument (RAI) Coordinator, Dietary Aide, residents and family members.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

A complaint was received by the Director regarding the provision of beverages to resident #006.

On a particular day, during the inspection, Inspector #196 observed one of the resident units between 1000hrs and 1100hrs and noted that the provision of morning beverages to residents had not occurred.

At 1120hrs, that same day, Inspector #196 conducted an interview with Dietary Aide #115. They reported that usually a cart was made up with water for the residents but that the staff had not reminded them that morning and it was not done. Interviews were also conducted with PSW #117, PSW #118, PSW #119, and they all confirmed that they had not provided a between-meal beverage to the residents of that unit that morning.

An interview was conducted with the Food Services Manager #104, who confirmed to Inspector #196 that the residents were to be provided with a beverage between 1000 and 1030hrs in the morning, everyday, both water and juices. In addition, the DOC #102 reported that a Dietary Aide was to prepare a cart with beverages for the PSWs to distribute, around 1000 to 1030hrs, everyday on each resident unit. [s. 71. (3) (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 that ensures that each resident is offered a minimum of, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

WN #2: 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. (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 resident #006 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.

A complaint was received by the Director regarding the provision of a specific type of care to resident #006.

The health care records for resident #006 was reviewed by Inspector #196 for information regarding a specific type of care. The current care plan as found online in Point Click Care (PCC) identified altered skin integrity. The progress notes on a specific date, identified that one area of altered skin integrity had healed and another area of altered skin integrity was being monitored and had preventative measures in place.

An interview was conducted with PSW #120 and they confirmed that resident #006 did not have altered skin integrity. An interview was conducted with Resident Assessment Instrument (RAI) Coordinator #116 and they confirmed that this resident no longer had areas of altered skin integrity. They proceeded to update the care plan with the current care needs regarding risk for impaired skin integrity. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (2) The licensee shall comply with subsection (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director. O. Reg. 79/10, s. 103 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee has complied with s. 103. (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director.

A review by Inspector #625 of a written complaint submitted from resident #002's family member to the home on a particular day in 2015, identified that the family member had concerns related to care received by the resident in the home. The written complaint was related to improper or incompetent care of resident #002 that resulted in a risk of harm to the resident. The complaint included specific concerns.

A review of a response letter from the Executive Director (ED) of the home to resident #002's family member, on a particular day in 2015, identified that the home had received the concerns in writing from the family member and would conduct an immediate review of the concerns.

During an interview with Inspector #625, the Director of Care (DOC) stated that a meeting had been held with resident #002's family member, the resident's physician, RN #103 and the DOC on a specific day to address the concerns identified in the written correspondence.

During an interview with Inspector #625, the Executive Director (ED) acknowledged that they had received the written complaint on a particular day in 2015 and that a meeting had occurred on the following day to address resident #002's family member's concerns. The ED stated that they had not immediately submitted a report to the Director documenting the response made by the licensee to the complainant, upon completing their investigation of the complaint. [s. 103. (2)]

Issued on this 31st day of October, 2016

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

Original report signed by the inspector.