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
Jul 25, 2018	2018_624196_0019	013081-18	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No. 9) GP Inc. as general partner of CVH (No. 9) LP
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Southbridge Pinewood
2625 Walsh Street East THUNDER BAY ON P7E 2E5

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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577), JENNIFER LAURICELLA (542), TIFFANY BOUCHER (543)

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): July 9 - 13, 16 - 19, 2018.

Additional intakes inspected during this Resident Quality Inspection (RQI) included:

One complaint related to housekeeping concerns;

One complaint related to water temperature, and dining services;

Three Critical Incident System (CIS) reports related to falls prevention and management;

Three CIS reports related to alleged resident abuse;

Two CIS reports related to an environmental hazard; and

One CIS report related to the medication management system.

The inspectors also conducted daily tours of the resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, internal investigation files, human resource files and resident health care records.

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, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT), Food Service Manager (FSM), Environmental Service Manager (ESM), Cook, Maintenance employee, Housekeeping Aides, Dietary Aides, Registered Dietitian (RD), residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **5 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

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

During a record review, resident #001 had been identified as having had an area of altered skin integrity.

During an interview with RPN #119, they reported to Inspector #577 that resident #001 currently had an area of altered skin integrity and treatments were to be done every three days.

During an interview with the Wound Care Champion RN #123, they reported to Inspector #577 that the "Initial Wound Assessment" was done upon discovery of a wound, and the "Ongoing Wound Assessment" was done once per week.

During a review of resident #001's health care records, Inspector #577 identified that the resident developed an area of altered skin integrity in 2017, and had required ongoing treatment since that time. The most current Weekly Wound Reassessment, indicated that resident #001 had an an area of altered skin integrity; the date of onset was documented as a specific date in 2017.

The home's policy titled "Skin and Wound Care - CARE12-010.02", revised July 31, 2016, indicated that staff were required to initiate a wound assessment using the "Initial Wound Assessment" and utilize the "Ongoing Weekly Wound Assessment" for weekly wound assessments.

The "Initial Wound Assessment/Treatment Observation Record" indicated that it was initiated on a specific date in 2017. During a review of the "Ongoing Weekly Wound Assessment" documentation, the Inspector found ten missing wound assessments over an approximate six month time period.

A record review of the resident's progress notes did not identify any wounds assessments for those time periods which had missing wound assessments.

Together, the DOC and Inspector #577 reviewed the "Ongoing Weekly Wound Assessment" documentation for resident #001, and the DOC confirmed that over an approximate six month time period, there were ten missing wound assessments for resident #001. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: 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 drugs were stored in an area or a medication cart that was secured and locked.

Inspector #577 toured the home and observed medicated topical treatments that were located in unlocked care carts located in resident hallways. Inspector #577 observed twelve medicated topical treatments not secured and locked, in three treatment carts, on a unit, while not in use or supervised by staff:

During an interview with PSW #124, PSW #125 and PSW #126, they reported to Inspector #577 that the medicated creams in the unlocked care carts should have been locked.

During an interview with RPN #117, they confirmed that the care carts should have been locked as they contained medicated topical treatments.

On another date, Inspector #577 observed medicated topical treatments that were in two unlocked care carts on a unit in an unlocked utility room; the utility room door was open at the time of the observation. Inspector #577 observed the eight medicated topical treatments not secured and locked, while not in use or supervised by staff:

During an interview with PSW #127, they reported that the utility room that contained the unlocked care carts with medicated creams should have been locked.

A review of the home’s policy titled “The Medication Storage - 3-4" revised January 2018, indicated that when medication carts were used to store all currently required medication, carts were to be locked at all times when not attended by a nurse.

During an interview with the DOC, they acknowledged that unsupervised care carts should have been locked when not in use as they contained medicated topical treatments. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart that was secured and locked, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review implemented; and a written record kept of everything provided for in clauses (a) and (b).

Inspector #577 reviewed the home's "Medication Incident Summary Report" for a three month time period in 2018. The report referred to 11 medication incidents which occurred in the home up to a specific date in 2018.

The Inspector reviewed the home's Professional Advisory Committee Meeting Minutes from a specific date in 2018, which indicated medication incidents as a topic of discussion.

During an interview with the DOC, they reported to Inspector #577 that there had not been a quarterly review undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review. They further reported that the committee only discussed the number of medication incidents which had occurred in the home since their last review [s. 135. (3)]

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 quarterly reviews are undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review are implemented; and a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A Critical Incident System (CIS) report was received by the Director in 2017, which alleged an incident of staff to resident abuse. The report alleged that on a specific date in 2017, while resident #016 had been provided with care by the staff, the resident had displayed responsive behaviours and accused the staff of abuse.

A record review of the progress notes documented by RPN #130, indicated that resident #016 had displayed responsive behaviours during the provision of care by the staff and identified that the resident had alleged that the staff had abused them during the provision of care.

A review of the home's policy titled "Resident Non-Abuse - ADMIN1-P10-ENT" revised July 31, 2016, indicated that Revera had zero tolerance for abuse and neglect; all persons involved with Revera homes had a duty to report any form of alleged, potential, suspected or witnessed abuse or neglect; anyone who became aware of or suspected abuse or neglect of a resident had to immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on shift.

During an interview with the DOC, they reported to Inspector #577 that they discovered the allegations when they had read the shift report on a specific date in 2017. They reported that RPN #130 did not report the incident to anyone, as they had reported that they felt the resident's allegations were not true. The DOC further confirmed that the allegations should have been reported by RPN #130 to the registered nurse, and the incident should have been reported immediately to the Director at the Ministry of Health and Long-Term Care. [s. 20. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were developed and implemented for, cleaning of the home, including, common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

A complaint was received by the Director with concerns regarding soiled and stained carpets within the home.

During the inspection, several stains and darkened areas were identified on two of the

unit corridors.

The Extendicare policy "Cleaning Frequency - HL-05-01-09", policy, and Appendix 1 titled "Recommended Cleaning Frequencies" indicated that hot water extract cleaning of the carpets was to be done as required and annually.

Maintenance staff #120 reported to the Inspector that they did carpet cleaning when time permitted.

The Environmental Services Manager (ESM) reported to the Inspector, that they were aware of the stained carpets on two of the unit corridors. They confirmed that the cleaning frequency for the current stains on the carpet was not being done as indicated in the homes' policy and procedure.

During an interview with the Administrator, they reported to the Inspector, that they were aware of carpet stains throughout the home and were waiting for a quote for carpet cleaning to be done by an outside company, on a rotational basis. [s. 87. (2) (a)]

2. The licensee has failed to ensure that, as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee developed and implemented for, cleaning and disinfection of the following in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices: supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Resident #002's assistive aid was observed to be soiled. The observations were made by Inspector #577 on one specific date and by Inspector #196 on two dates in 2018.

The home's policy titled "Resident Care Equipment - RC-07-01-01", indicated that resident care equipment included wheelchairs and mobility aids and regular cleaning of these items was recommended. In addition, the ADOC provided the Point of Care (POC) record for a one week time period in 2018, which did not identify that resident #002 had their assistive aid cleaned. The ADOC also provided the Inspector with the, "Pinewood Court Job Routines" which advised night shift staff to "Commence cleaning schedule of wheelchairs for residents who are to be bathed on upcoming day". Resident #002 was identified as scheduled for a bath on a day of the week with an asterix beside their name. This represented the one time weekly in which wheelchairs or basins were to be washed

on the previous night shift.

On a date during the inspection, PSW #122 confirmed to the Inspector that resident #002's assistive aid was soiled. The PSW went on to report that it should have been cleaned when it was observed and also should have been cleaned on the night shift before the resident's bath day.

During an interview with the DOC, they reported that each home area had a bath list and their mobility device or aid would be cleaned the night before the bath. The DOC indicated that if a personal item, ie. walker, wheelchair was soiled they were required to be cleaned at the time it was observed to be unclean. [s. 87. (2) (b)]

Issued on this 25th day of July, 2018

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

Original report signed by the inspector.