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

Division de la responsabilisation et de la performance du système de santé
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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
Aug 31, 2015	2015_270531_0023	O-002375-15	Resident Quality Inspection

Licensee/Titulaire de permis

LAND O'LAKES COMMUNITY SERVICES
12497A Hwy 41 PO Box 92 Northbrook ON K0H 2G0

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

PINE MEADOW NURSING HOME
124 Lloyd Street P.O. Box 100 Northbrook ON K0H 2G0

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

SUSAN DONNAN (531), AMBER MOASE (541), WENDY BROWN (602)

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 17, 18, 19, 20, 21, 24 and 25, 2015

Log # O-001466-15, Log # O-001537-15, Log #O-001878-15, Log # O-001929-15 and Log #O-002467-15 included in this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Resident Substitute Decision Makers, Personal Support Workers, Registered Practical Nurses, Registered Nurses, the Maintenance manager, the RAI Coordinator, Resident Program manager, a Physician,the Nutrition Supervisor, the Director of Care and the Administrator.
During the course of the inspection the inspectors also toured the home, observed Resident care and services including dining observations, reviewed staff scedules, the falls prevention program, maintenance program and applicable policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

2 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, c.8, s.24. in that suspected neglect of a resident was not immediately reported to the Director.
On a specified date Resident #44 was found on the commode by evening staff shortly after starting their shift at 1400 without the call bell in reach. The Resident had been toileted at 13:45 by day staff who checked on the resident before leaving and as the Resident was not done the transfer was left to the next shift who did not receive the message that Resident #44 needed to be transferred off the commode. The nurse in charge notified the Director of Care of the incident.

The Administrator and Director of Care where interviewed on August 25, 2015 and acknowledged that the report to the Director was submitted two days following the incident. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

During an observation of the lunch meal on August 17, 2015 it was noted that Residents #5, 10, 31, 33 and 45 were all provided with their dessert while they were still eating their entrée. Resident #46 was noted to have her soup, entrée and dessert in front of her simultaneously. The Residents all required assistance with their meals.

During an interview on August 25, 2015 PSW staff member #S112 stated that residents who require assistance at meals are provided with their soup and entrée at the same time. PSW #S112 states residents who are independent are provided with one course at a time.
On August 25, 2015 during an interview with inspector #541, PSW staff member #S115 stated she has not been provided with any education regarding proper meal service in the dining room and she has learned from watching others. PSW #S115 stated that if a resident is still eating their soup and their entrée is ready to be served, the entrée would be left on the table beside them. [s. 73. (1) 8.]

Issued on this 31st day of August, 2015

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

Original report signed by the inspector.