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
Nov 24, 2016	2016_505103_0054	030540-16, 032163-16	Critical Incident System

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 23, 2016

The following intakes were included in this inspection: Log# 030540-16 (alleged staff to resident abuse), Log #032163-16 (resident fall).

During the course of the inspection, the inspector(s) spoke with residents, the RAI coordinator, a Registered Nurse and the Director of Care.

The inspector reviewed resident health care records, the home's investigation into the alleged staff to resident abuse and made resident observations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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 following finding relates to Log #030540-16:

The licensee has failed to ensure resident #001 received care in accordance with the

plan of care.

Resident #001 was admitted to the home on an identified date and had identified diagnoses. The resident had been assessed as high risk for falls. The home submitted a critical incident and reported on an identified date, RPN #100 entered resident #001's room and found the resident fully dressed in their wheelchair, with hearing aides and dentures in place. The resident indicated they had been in the wheelchair all night and that no one had assisted them with getting ready for bed.

Resident #001 was interviewed and indicated recall of that evening and night. The resident stated they prefer to go to bed between 2000 and 2100 hour, but that no one came to assist them. The resident stated they became very tired and recalled falling asleep and wakening several times while in the wheelchair. The resident indicated they thought someone would be along at some point to help them into bed and that staff usually come into the room during the night to provide assistance with toileting. According to resident #001, they preferred the door shut at all times.

Resident #001's plan of care was reviewed and indicated the following:
Under "Sleep and Rest Patterns"-resident prefers to go to bed at approximately 2100 hours.
Under "ADL-Toilet use"- night time toileting routine, resident will use sit to stand lift/Sara from bed to commode and commode back to bed.
Under "Falls"-safety checks as resident attempts to transfer themselves.
Under "Communication"-assist resident with hearing aides every am and at bedtime.
Under "Dental"-remove and soak dentures every night.

The DOC was interviewed and stated the home investigated the incident. PSW #101 had been assigned to care for resident #001 on the evening of an identified date and during the interview indicated the resident had refused offers of bedtime assistance on three occasions. The PSW finished the shift and did not advise the registered staff of the refusals and that she had not provided care to resident #001. When interviewed by the DOC, PSW #101 stated she assumed another PSW had completed resident #001's care as they often work as a team. In addition, the DOC stated PSW #101 had documented in the electronic record that bedtime care was provided to resident #001. The PSW received disciplinary action as a result.

The DOC stated some of the staff believed resident #001 did not like to be disturbed during the night and were therefore, not making regular checks on the resident

throughout the night. The DOC stated this was contrary to the resident plan of care. She had a discussion with both the resident and the family who agreed night time checks by staff would be important to ensure the resident's safety and to provide any toileting assistance that may be required. The DOC indicated all staff have been asked to review the updated plan of care for resident #001.

Resident #001 was provided with care upon being found on the identified date and suffered no untoward effects of being left in the wheelchair overnight. [s. 6. (7)]

Issued on this 24th day of November, 2016

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

Original report signed by the inspector.