Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Ottawa District**
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

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|---|---|
| **Report Issue Date: October 16, 2023** | |
| **Inspection Number:** 2023-1286-0005 | |
| **Inspection Type:**<br>Complaint | |
| **Licensee:** Land O'Lakes Community Services | |
| **Long Term Care Home and City:** Pine Meadow Nursing Home, Northbrook | |
| **Lead Inspector**<br>Darlene Murphy (103) | **Inspector Digital Signature**<br>Darlene Murphy Digitally signed by Darlene Murphy Date: 2023.10.27 09:14:46 -04'00' |
| **Additional Inspector(s)** | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 27, 28, October 3, 4, 2023.

The following intake(s) were inspected:

- Intake: #00096159 - complaint related to resident care,
- Intake: #00097761 - complaint related to an alleged resident to resident abuse.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards

## INSPECTION RESULTS

## WRITTEN NOTIFICATION: Responsive Behaviours

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee failed to ensure there were written strategies, including techniques and interventions, to prevent, minimize or respond to a resident's responsive behaviours.

**Rationale and Summary:**
The Activity Aide (AA) observed a resident inappropriately touching another resident. The AA stated this was a known responsive behaviour for the resident and both residents were kept separated as much as possible.

Additional staff members were interviewed including a Personal Support Worker (PSW), a Registered Practical Nurse (RPN) and a Behavioural Supports Ontario worker (BSO) who all indicated the resident was known for exhibiting this type of behaviour.

The resident's plan of care was reviewed related to responsive behaviours. The plan failed to identify this responsive behaviour and did not include written strategies, techniques or interventions to prevent, minimize or respond to the responsive behaviours.

Failure to ensure there are written strategies to minimize or respond to resident behaviours, places other residents at risk of harm and abuse.

**Sources**: Interviews with AA, PSW, RPN, and BSO, resident health care record.
[103]

## WRITTEN NOTIFICATION: Policy to promote zero tolerance

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure a Registered Practical Nurse complied with the home's zero tolerance of abuse policy.

**Rationale and Summary:**
The home's zero tolerance of abuse policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", states any employee who becomes aware of an alleged, suspected or witnessed incident of resident abuse will report it immediately to the Administrator/Designate/Reporting manager, or if unavailable the most senior shift supervisor on shift at that time.

The Activity Aide (AA) observed a resident inappropriately touching another resident. After safeguarding the resident, the AA reported the incident to the RPN. The RPN was interviewed and indicated they were aware of similar past incidents involving the two residents and the aggressor in this incident had previously been advised to have no contact with the other resident. The RPN stated they believed this incident constituted resident abuse, but confirmed they did not report the incident to the charge staff or the Director.

Failure to comply with the home's abuse policy places residents at risk of harm and abuse.

**Sources**: Home's abuse policy, interviews with the AA and the RPN.
[103]

## WRITTEN NOTIFICATION: Bathing

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee failed to ensure residents of the home were bathed, at a minimum, twice a week by the method of their choice.

**Rationale and Summary:**
Three residents were interviewed and stated they did not always receive their second bath of the week. All stated the missed baths were usually on weekends and they were told by staff the baths had to be cancelled as a result of staffing. The residents stated the missed baths were not rescheduled. Bathing records were reviewed and showed evidence of baths being missed. Personal Support Worker (PSW) staffing schedules were reviewed, and the missed baths corresponded with times when the staffing compliment was decreased.

The Acting Director of Care (Acting DOC) stated the home did have vacant PSW positions on every other weekend which may have contributed to the missed resident baths. The Acting DOC stated additional

PSW's had recently been hired.

Failure to provide twice weekly baths to residents in accordance with the method of their choice, affects resident self-esteem and feelings of well-being.

**Sources**: Interviews with residents, review of resident bathing records, and PSW staffing schedules. [103]