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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2014	2014_280541_0010	O-OOO290-14	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

AMBER MOASE (541)

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): April 16, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Education Co-ordinator, a Registered Practical Nurse, a Personal Support Worker, a Housekeeper.

During the course of the inspection, the inspector(s) reviewed the home's investigation records, reviewed resident health care records, reviewed policies #OPER-02-02-14 and #OPER-03-01-14.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007 c.8 s 22(1) whereby the home who received a written complaint concerning the care of a resident or the operation of the long-term care home did not immediately forward it to the Director.

On March 30, 2014 the home received a written letter of complaint describing an alleged incident of abuse towards Resident #1. The Director of Care reported this to the Director electronically via the Central Intake Assessment Triage Team (CIATT). A review of the Critical Incident report 2796-000006-14 indicates the home was requested by CIATT to forward this complaint letter to the Director. On April 17, 2014, Inspector 541 contacted CIATT and it was confirmed a letter of complaint was not received from the home.

On April 22, 2014 during a phone conversation with Inspector 541, the Administrator confirmed the written complaint was not forwarded to the Director. [s. 22. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 97(1)b whereby the licensee did not ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident was notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On March 30, 2014 the home received a written complaint from a visiting family member regarding a suspected incident of abuse towards resident #1. Progress notes for Resident #1 were reviewed from March 29, 2014- April 16, 2014 and there are no notes to indicate when or if Resident #1's substitute decision-maker was contacted regarding this incident.

On April 16, 2014 during an interview with Inspector 541, the Adminstrator confirmed the substitute decision maker for Resident #1 was notified on the morning of April 1, 2014.

The substitute decision maker for Resident #1 was not notified within 12 hours of the home becoming aware of an alleged incident of abuse. [s. 97. (1) (b)]

2. The licensee has failed to comply with O. Reg 79/10 s. 97(2) whereby the licensee did not ensure that the resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23(1) of the Act, immediately upon completion of the investigation.

On March 30, 2014 the home received a written complaint regarding a suspected incident of abuse towards resident #1.

On April 16, 2014 during an interview with Inspector 541, the Administrator confirmed the substitute decision-maker for Resident #1 was not notified upon completion of the investigation of alleged abuse or neglect towards Resident #1. [s. 97. (2)]

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Issued on this 25th day of April, 2014

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

Amber Moase