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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 3, 2016	2016_339617_0011	000941-16	Critical Incident System

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive KENORA ON P9N 2W7

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

PINECREST
1220 VALLEY DRIVE KENORA ON P9N 2W7

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

SHEILA CLARK (617)

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 25, 26, 27, 28, 29, 2016.

This Critical Incident Inspection is related to the following four critical incident reports submitted by the home to the Director:
-staff to resident abuse
-resident to resident abuse
-resident fall that resulted in injury.

This inspection was conducted concurrently with Complaint Inspection #2016_339617_0012 and Follow Up Inspection #2016_339617_0014.

Findings of non-compliance regarding mandatory reporting LTCHA, 2007, S. O. 2007, c. 8, s. 20 (1), and s. 23 (2), found in this inspection were issued in the Complaint Inspection #2016_339617_0012.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), Human Resources Manager (HRM), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Housekeepers (HSK), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), residents and family.

Observations were made of the home areas, meal services, and the provision of care and services to residents during the inspection. The home's policies and procedures, resident health records and staff training and personnel records were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 WN(s)
1 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was reassessed and their plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

A Critical Incident Report was submitted by the home to the Director regarding resident #002 involved in an alleged altercation with resident #003.

A review of the CI indicated that a family member reported they witnessed resident #002 become physically aggressive with resident #003. The CI also indicated that the same family member reported residents were afraid of resident #002 due to their responsive behaviours.

A review of the home's investigation notes concluded that the alleged altercation between resident #002 and resident #003 did not occur as there was no evidence.

Inspector #617 reviewed resident #002's historic records that indicated at the time of the incident, a Resident Assessment Data Minimal Set (RAI-MDS) assessment of cognitive loss and a medical condition which resulted in responsive behaviour.

A review of resident #002's care plan indicated a list of behavioural problems and a list of interventions for the PSWs and registered staff to manage those behaviours.

The home referred resident #002 to a community resource team to help assist them in managing the resident's responsive bevhaviours. the resource team assessed resident #002 and provided support to the home with various strategies to engage the resident.

Despite interventions identified in resident #002's care plan to manage responsive behaviours and the resource team who attended the resident, it was evident that resident #002 had many episodes of responsive behaviour affecting the safety of other residents living on the unit. A review of resident #002's progress notes dated over a six month period indicated a total of 48 episodes of responsive behaviours that mostly occurred in the evening and during the night which involved risk to other residents' safety.

Inspector #617 interviewed the DOC who confirmed that interventions in resident #002's care plan were implemented by the staff and the resource team but the resident still managed to have responsive behaviours which may have put the safety of other residents at risk.

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 to ensure that resident #002 and all other residents will be reassessed and their plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004's substitute decision-maker (SDM), 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.

A CI report of staff to resident abuse was reported to the Director involving resident #004 . A review of the home's investigation notes indicated that a staff member witnessed a member of the registered staff verbally abuse resident #004 during the medication pass. The alleged verbal abuse triggered resident #004 to have responsive behaviours.

A review of the home's investigation of the CI determined that verbal abuse did not occur.

Inspector reviewed resident #004's progress notes around the time the CI had occurred and the home's investigation notes; and did not find evidence that the resident's SDM was notified of the incident or that the home had conducted an investigation.

Inspector reviewed the home's policy titled "Zero Tolerance of Abuse and/or Neglect - ADM 450" revised on June 2015, which indicated that staff must notify the SDM, if any, or any other person specified by the resident immediately when becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of a resident for all other situations.

On April 29, 2016, the Inspector interviewed the DOC who confirmed that the home did not call resident #004's SDM to inform them of the alleged verbal abuse of the resident and should have. [s. 97. (1) (b)]

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Issued on this 16th day of June, 2016

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

Original report signed by the inspector.