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

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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
Feb 22, 2017	2016_325568_0030	033794-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

PINECREST MANOR
399 BOB STREET P.O. BOX 220 LUCKNOW ON N0G 2H0

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

DOROTHY GINTHER (568), REBECCA DEWITTE (521), SHARON PERRY (155)

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): December 12, 13, 19, 2016 and January 3, 6, 11, 2017.

A complaint IL-47702-LO log # 031392-16 and Critical Incident #2600-000020-16 log # 031366-16 related to alleged staff to resident abuse; and a follow-up to CO #001 log # 010965-16 from inspection 2016_325568_0007 related to responsive behaviours were conducted in conjunction with the inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director / Director of Care, Assistant, Director of Care / RAI Coordinator, Regional Manager of Clinical Services, Environmental Services Manager, Food Services Manager, Recreation Manager, Office Manager, two Registered Practical Nurses, seven Personal Support Workers, one Nurses Aide, one Recreation Aide, a Resident Council representative, residents and their families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **8 VPC(s)**
- **1 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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) Identifying factors, based on a an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) Identifying and implementing interventions.

Review of an identified resident's most recent Minimum Data Set (MDS) assessment identified that the following responsive behaviours occurred on one to three days of the last seven: verbal aggression, physical aggression, socially inappropriate behaviours and resistance to care. In all cases it was indicated that the behaviours were not easily altered.

The Plan of Care for the identified resident stated that the resident exhibited responsive behaviours that included physical aggression, verbal outbursts and socially inappropriate behaviours.

Review of the identified resident's clinical record outlined a number of incidents when the resident exhibited verbal outbursts directed at both staff and residents which often disrupted activities within the home. In addition, it was documented that the resident would taunt and torment other residents which could lead to physical aggression and altercations amongst residents. The resident was not easily redirected and in many cases when staff intervened it was documented that the resident's behaviours escalated.

On a specified date the identified resident was observed between 0930 and 1210 hours. The resident was observed exhibiting socially inappropriate behaviours towards other residents and at one point they were physically aggressive with a co-resident.. At no time during this period was the resident engaged in a specific activity nor was the resident approached by staff to participate in an activity.

During staff interviews with two Personal Support Workers (PSW) they shared that the identified resident exhibited a number of responsive behaviours which included verbal aggression, resistance to care, physical aggression toward staff and residents, as well as socially inappropriate behaviours. One of the PSW's recalled an incident just the other day where they observed the resident taunting another resident which led to a physical altercation. Staff indicated that the resident's responsive behaviours, identified triggers and strategies to effectively manage the behaviours were documented on the resident's care plan / kardex which was accessible to staff.

During an interview with a Registered Practical Nurse (RPN) / BSO lead and a BSO PSW they shared that the identified resident had been followed by the home's BSO team. They further shared that the identified resident's responsive behaviours had worsened over the last few months and it was often difficult to intervene and de-escalate the behaviours. When shownthe resident's plan of care related to responsive behaviours, the RPN/ BSO lead acknowledged that the identified triggers were not included. In terms of strategies to manage these behaviours, the staff member stated that they had developed and implemented some strategies but not specific to the identified triggers. They acknowledged that many of these strategies were reactionary rather than preventative.

In an interview with the ADOC / RAI Coordinator, they stated that the identified resident had a history of responsive behaviours and that they had escalated over the last few months. The ADOC / RAI Coordinator acknowledged that triggers for the resident's responsive behaviours had not been identified on the resident's plan of care. In addition, some of the resident's newly demonstrated responsive behaviours had not been added to the plan of care and therefore there were no identified strategies in place to address these behaviors. The ADOC / RAI Coordinator acknowledged that the home had not put specific measures in place to address the resident's triggers which may have contributed to altercations between and among residents.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

The severity of this area of noncompliance was identified as potential for actual harm and the scope was isolated. There was an outstanding compliance order that was issued on April 13, 2016 with a compliance date of May 30, 2016 [s. 54. (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).

11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A review of the home's internal investigation pertaining to an alleged incident of staff to resident abuse was conducted. A written statement by a Personal Support Worker (PSW) indicated that the PSW had witnessed the incident of alleged abuse as described in the investigation notes.

During an interview with the PSW they acknowledged having witnessed an incident of staff to resident abuse. Review of a documented interview completed by the home's internal investigation team indicated that the staff member involved in the incident admitted to having been rough with the identified resident. There were no documented injuries as a result of this incident.

During an interview with the Assistant Director of Care (ADOC) / RAI Coordinator they said that they had investigated the alleged incident of abuse involving an identified resident and a staff member. The ADOC / RAI Coordinator shared that following their internal investigation the staff member involved had been disciplined for their actions.

The licensee failed to respect the identified resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

The severity of this area of noncompliance was identified as minimal harm with potential for actual harm and the scope was isolated. This area of noncompliance was a level two, one or more unrelated noncompliance in the last three years. (532) [s. 3. (1)]

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 every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #3: 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 licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During a review of an identified resident's plan of care related to bowel management, an order for a daily medication was noted. The resident also had a bowel protocol order which indicated that on day three if the resident had not had a bowel movement they were to be given a specified amount of Milk of Magnesia suspension form. On day five if they still had not had a bowel movement they were to be given a suppository.

Documentation on Point of Care (POC) tasks for the identified resident indicated that the resident did not have a bowel movement for a four day period. During a review of the Medication Administration Record (MAR) and progress notes for that same time period there was no documentation that the resident received the Milk of Magnesia as per day three of the Bowel Protocol. Records did indicate that on day four when the resident had no bowel movement, the resident had refused their daily medication that had been prescribed for bowel management. The resident was examined by a physician on the fourth day of having no bowel movement and according to the resident's SDM, they were advised by the physician that the resident was severely constipated.

During an interview with the Assistant Director of Care (ADOC) / RAI Coordinator they shared that each night, staff reviewed the bowel movement (BM) twenty-four hour report and identified those residents that had not had a bowel movement. Based on the Bowel Management protocol, interventions were provided to the identified residents the following day. The Assistant Director of Care / RAI Coordinator stated that the identified resident should have been given Milk of Magnesia as per the physicians orders for day three of the BM protocol. The ADOC / RAI Coordinator acknowledged that care was not been provided to the resident with respect to bowel management as per the resident's plan of care.

The severity of this area of noncompliance was identified as potential for actual harm and the scope was isolated. This area of noncompliance was previously issued as a voluntary plan of correction on November 23, 2015. [s. 6. (7)]

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 the care set out in the plan of care was provided tot he resident as specified int he plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

During a review of the Residents' Council Meeting minutes for the period of June 1, 2016 through December 31, 2016 the following concerns were identified:

i) October 11, 2016 - members of council did not feel there was enough staff on the floor to meet the needs of residents in a timely
ii) November 8, 2016 - council asked why the building could not have regulated heating.

There were no documented concern forms completed for these concerns and no documented responses to the concerns that were raised.

During an interview with the Residents' Council Assistant (RCA) they stated that they had taken over this position in June 2016 when the regular staff went on a leave. The RCA was not aware of a specific form that was to be completed when concerns were raised at Residents' Council meetings. When a concern was identified at a meeting the RCA said they would send an email to the individual that was covering for the Executive Director / Director of Care (ED/DOC). The concern was also documented in the minutes. According to RCA, the ED/DOC position had been vacant from August through November 2016. RCA acknowledged that in the last few months they had not responded to concerns raised by the by the Residents' Council.

The licensee failed to respond to concerns or recommendations brought forward by the Residents' Council.

The severity of this area of noncompliance was identified as minimal risk and the scope was considered a pattern. The compliance history was a level two with one or more unrelated noncompliance in the last three years. [s. 57. (2)]

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 the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when there was no Family Council, the licensee on an on-going basis, advises families and persons of importance to residents of their right to establish a Family Council.

During an interview with the Executive Director / Director of Care (ED / DOC), they stated that currently there was no Family Council in the home. The ED / DOC indicated that they were fairly new to the home and were unsure how long it had been since the home had an active Family Council.

During an interview with the home's Office Manager they shared that the home sends out a monthly newsletter to families and substitute decision makers (SDM) of residents. The Office Manager stated that the newsletter had not included information regarding the establishment of a Family Council in the home nor did the Admission Package provided to new residents and their families. On January 6, 2017, the Assistant Director of Care / RAI Coordinator acknowledged that on an on-going basis, the home had not advised families and persons of importance to residents of their right to establish a Family

Council. [s. 59. (7) (a)]

2. The licensee has failed to ensure that if there was no Family Council, the licensee convenes semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

During an interview with the Executive Director / Director of Care (ED / DOC), they shared that they were new in their position having started in the last couple of months. The ED / DOC stated that to their knowledge a Family Council was not operating within the home. The Recreation Manager stated that they had commenced an interim position in June 2016 and since that time there had been no Family Council.

Record review identified minutes of a Family Council Meeting held on April 12, 2016. There were eleven names of family and/or persons of importance on the attendance sheet. There were no further minutes of Family Council meetings available.

During an interview with the Assistant Director of Care / RAI Coordinator, they shared that it had been some time since they had an active Family Council in the home. The ADOC / RAI Coordinator stated that over the last year they had several management team changes and had not convened a meeting since April 2016 to advise residents' families and persons of importance to residents of their right to establish a Family Council.

The severity of this area of noncompliance was identified as minimal risk and the scope was considered a pattern. The compliance history was a level two with one or more unrelated noncompliance in the last three years. [s. 59. (7) (b)]

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 when there is no Family Council, the licensee on an on-going basis, advises families and persons of importance to residents of their right to establish a Family Council; and the licensee convenes semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that they consult regularly with the Residents' Council, and in any case, at least every three months.

Review of the minutes of the Residents' Council for the period of January 1, 2016 through December 31, 2016 identified that the Executive Director / Director of Care had been consulting with the Residents' Council and providing regular updates during the first six months of 2016. The last update / consultation was provided in July 2016 after which the ED / DOC resigned from their position at the home. There was no consultation by the licensee with the Residents' Council since that time.

During an interview with the Residents' Council Chair they shared that the previous ED / DOC used to attend meetings on a fairly regular basis, and always when invited, to provide updates on any changes or new initiatives in the home. Since they left the Residents' Council Assistant (RCA) had done their best to answer questions or to seek a response from someone else in the home.

On January 11, 2017, during an interview with the RCA #115 they shared that since they assumed this role in June 2016 they could not recall the licensee consulting with the Residents' Council. The only other staff that attended meetings when invited was the Food Services Manager. The RCA stated that they did their best to update the residents but they were not always aware of changes themselves.

The licensee failed to consult regularly with the Residents' Council, and in any case, at least every three months.

The severity of this area of noncompliance was identified as minimal risk and the scope was considered a pattern. The compliance history was a level two with one or more unrelated noncompliance in the last three years. [s. 67.]

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 the licensee consults regularly with the Residents' Council, and in any case, at least every three months, to be implemented voluntarily.

WN #7: 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

During a review of the Residents' Council minutes for the period from January 1, 2016 through December 31, 2016, there was no documentation to indicate that the meal and snack times had been reviewed at one of the meetings.

On January 11, 2017, the Residents' Council Chair stated that they were not sure if the meal and snack times were reviewed at one of their meetings. If it was done then it would be documented in the minutes.

During an interview with the Food Services Manager (FSM), they shared that the Residents' Council had invited the FSM to their meetings on occasion if they had specific issues to discuss. When asked if they had reviewed the meal and snack times at the Residents' Council meetings during the last year, the FSM said that they had not.

The severity of this area of noncompliance was identified as minimal risk and the scope was considered a widespread. The compliance history was a level two with one or more unrelated noncompliance in the last three years. [s. 73. (1) 2.]

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 the dining and snack service included a review of the meal and snack times by the Residents' Council, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the satisfaction survey were made available to the Residents' Council in order to seek the advice of the Council about the survey.

During a review of the minutes of Residents' Council meetings for the period of January 1, 2016 through December 31, 2016, there was no documentation to indicate that the results of the most recent annual satisfaction survey had been shared with the Residents' Council.

During an interview with the Chair of the Residents Council, they were unable to recall whether the satisfaction survey results were shared at a Residents' Council meeting. The Resident's Council Assistant said that they could not recall presenting the results of the annual satisfaction survey. The RCA indicated that if this was done it would have been reflected in the meeting minutes.

The licensee failed to ensure that the results of the satisfaction survey were made available to the Residents' Council.

The severity of this area of noncompliance was identified as minimal risk and the scope was considered a widespread. The compliance history was a level two with one or more unrelated noncompliance in the last three years. [s. 85. (4) (a)]

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 the results of the satisfaction survey were made available to the Residents' Council in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A record review of Critical Incident System (CIS) #2600-000020-16 identified that on a specified date, the Ontario Provincial Police force (OPP) attended the home at the request of a Substitute Decision Maker (SDM).

During an interview with the SDM, they said that they had contacted the police force to ensure appropriate actions were being taken with respect to an alleged incident of abuse involving an identified resident.

The ADOC / RAI Coordinator acknowledged that the home had not notified the police force of the alleged incident of abuse related to the identified resident. During the interview they further shared that it was the homes expectation that the appropriate police force be immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The severity of this area of noncompliance was identified as minimal harm with potential for actual harm and the scope was isolated. The compliance history was a level two with one or more unrelated noncompliance in the last three years. [s. 98.]

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 the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #10: 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 ensure that the person, who had reasonable grounds to suspect abuse had occurred of a resident or may occur of a resident, immediately reported the suspicion and the information upon which it was based to the Director.

A review of Critical Incident System (CIS) #2600-000020-16 identified an incident of alleged abuse involving a resident and a staff member. The CIS report submitted to the Ministry of Health and Long Term Care indicated that it was submitted two days after the alleged incident had occurred.

During an interview with the ADOC / RAI Coordinator, they acknowledged that CIS report 2600-000020-16 was late in being reported to the Director. The ADOC / RAI Coordinator said that it was the home's expectation that the person who had reasonable grounds to suspect abuse of a resident immediately reported the suspicion and the information upon which it was based to the Director.

The severity of this area of noncompliance was identified as minimal risk and the scope was isolated. The compliance history was a level two with one or more unrelated noncompliance in the last three years. [s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included:
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

During stage 1 of the Resident Quality Inspection a resident reported that they were missing items from their room The resident stated that they had reported the items missing to staff and had not heard anything.

Review of the home's complaints and concerns binder identified a Client Services Response Form which was not dated. Under the title "name of resident" it was identified as the specified resident. The complaint / concern brought forward by the resident's SDM stated that the resident had various articles missing from their room and there were other residents entering the room despite the yellow barrier. Family indicated that they had complained previously and felt something should be done. The response form indicated that an initial contact was made with the complainant. It was documented that a representative from the home would get back to the complainant the following week to update them on the missing items.

During an interview with the Assistant Director of Care / RAI Coordinator, they reported that a concern was raised by the identified resident's SDM regarding missing items and it was documented in their complaints and concerns log book. Unfortunately the concern was brought forward when they had a number of staffing changes and they did not follow through on the investigation and follow-up. The ADOC / RAI Coordinator acknowledged that there was no documentation as to the type of action taken to resolve the complaint including, the date of the action, time frames for actions to be taken, followup action, final resolution, and response made to the complainant.

The severity of this area of noncompliance was identified as minimal harm with potential for actual harm and the scope was isolated. The compliance history was a level two with one or more unrelated noncompliance in the last three years. [s. 101. (2)]

Issued on this 26th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), REBECCA DEWITTE (521), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2016_325568_0030
Log No. / Registre no:	033794-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 22, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT,8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	PINECREST MANOR 399 BOB STREET, P.O. BOX220, LUCKNOW, ON, N0G-2H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Margaret deBoer

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_325568_0007, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall ensure that for identified resident and any other resident exhibiting responsive behaviours, that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying factors that could potentially trigger such behaviours, and implementing strategies to minimize these triggers and the risk of altercations.

Grounds / Motifs :

1. The licensee failed to comply with order # 001 from inspection # 2016_325568_0007 served on April 13, 2016. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) Identifying factors, based on a an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) Identifying and implementing interventions.

Review of an identified resident's most recent Minimum Data Set (MDS) assessment identified that the following responsive behaviours occurred on one to three days of the last seven: verbal aggression, physical aggression, socially inappropriate behaviours and resistance to care. In all cases it was indicated

that the behaviours were not easily altered.

The Plan of Care for the identified resident stated that the resident exhibited responsive behaviours that included physical aggression, verbal outbursts and socially inappropriate behaviours.

Review of the identified resident's clinical record outlined a number of incidents when the resident exhibited verbal outbursts directed at both staff and residents which often disrupted activities within the home. In addition, it was documented that the resident would taunt and torment other residents which could lead to physical aggression and
altercations amongst residents. The resident was not easily redirected and in many cases when staff intervened it was documented that the resident's behaviours escalated.

On a specified date the identified resident was observed between 0930 and 1210 hours. The resident was observed exhibiting socially inappropriate behaviours towards other residents and at one point they were physically aggressive with a co-resident. At no time during this period was the resident engaged in a specific activity nor was the resident approached by staff to participate in an activity.

During staff interviews with two Personal Support Workers (PSW) they shared that the identified resident exhibited a number of responsive behaviours which included verbal aggression, resistance to care, physical aggression toward staff and residents, as well as socially inappropriate behaviours. One of the PSW's recalled an incident just the other day where they observed the resident taunting another resident which led to a physical altercation. Staff indicated that the resident's responsive behaviours, identified triggers and strategies to effectively manage the behaviours were documented on the resident's care plan / kardex which was accessible to staff.

During an interview with a Registered Practical Nurse (RPN) / BSO lead and a BSO PSW they shared that the identified resident had been followed by the home's BSO team. They further shared that the identified resident's responsive behaviours had worsened over the last few months and it was often difficult to intervene and de-escalate the behaviours. When shown the resident's plan of care related to responsive behaviours, the RPN/ BSO lead acknowledged that the identified triggers were not included. In terms of strategies to manage these

behaviours, the staff member stated that they had developed and implemented some strategies but not specific to the identified triggers. They acknowledged that many of these strategies were reactionary rather than preventative.

In an interview with the ADOC / RAI Coordinator #101, they stated that the identified resident had a history of responsive behaviours and that they had escalated over the last few months. The ADOC / RAI Coordinator acknowledged that triggers for the resident's responsive behaviours had not been identified on the resident's plan of care. In addition, some of the resident's newly demonstrated responsive behaviours had not been added to the plan of care and therefore there were no identified strategies in place to address these behaviors. The ADOC / RAI Coordinator acknowledged that the home had not put specific measures in place to address the resident's triggers which may have contributed to altercations between and among residents.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

The severity of this area of noncompliance was identified as potential for actual harm and the scope was isolated. There was an outstanding compliance order that was issued on April 13, 2016 with a compliance date of May 30, 2016.

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

Service Area Office /
Bureau régional de services : London Service Area Office