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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 12, 2017	2017_363659_0021	021094-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

JANETM EVANS (659), CAROLEE MILLINER (144), HELENE DESABRAIS (615), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 5, 6, 7, 8, 11, 12, 13 and 14, 2017.

The following follow up inspection and intakes were completed at the time of this inspection:
Log #012908-16\2600-000010-16 critical incident related to alleged staff to resident abuse;
Log #030175-16\2600-000017-16 critical incident related to alleged staff to resident

abuse;
Log #031389-16\2600-000021-16 critical incident related to alleged improper care/abuse;
Log#032152-16\2600-000022-16 critical incident related to alleged improper care resulting in fall;
Log #003406-17\ 2600-000003-17 critical incident related to alleged staff to resident abuse/neglect;
Log# 004786-17\2600-000004-17 critical incident related to alleged staff to resident abuse/neglect;
Log# 005610-17\2600-000007-17 critical incident related to alleged staff to resident verbal abuse;
Log#008806-17\2600-000011-17 critical incident related to resident fall;
Log #010549-17\2600-000012-17 critical incident related to alleged staff to resident neglect;
Log# 020876-17\2600-000017-17 critical incident related to alleged abuse;
Log#007361-17 Follow up to Compliance Order #001 from inspection #2016_325568_007 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Executive Director/Director of Care, the Assistant Director of Care, Regional Manager of Education and Resident Services, the Recreation Services Manager, Registered Nurses, Registered Practical Nurses, the Social Worker, the Registered Dietitian, the Pharmacist, the Staff Educator, Personal Support Workers, Physiotherapy Assistant, Dietary Aide, Housekeeping/Laundry Aides, the Resident Council President, a Family Council Representative and Residents and Family members.

The inspector(s) conducted a tour of the home, and reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures and Residents' and Family Council minutes. Observations were also made of the provision of care, staff to resident interactions, medication administration and storage areas, infection prevention and control practice, general maintenance cleanliness, and condition of the home and required Ministry of Health and Long-Term Care postings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **10 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **1 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 had 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 an interdisciplinary assessment and on information provided to the licensee or staff or through observations, that could potentially trigger such altercations; and
(b)identifying and implementing interventions.

A review of the clinical record for an identified resident showed incidents where the resident exhibited specific responsive behaviours.

A Behaviour Support Ontario (BSO) referral had been initiated November 2016, for the identified resident's behaviour.

A Physical, Intellectual, Emotional, Capabilities, Environment and Social (PIECES) assessment was reviewed which identified environmental triggers affecting the residents behaviours. There was no follow up or plan documented related to the assessment. The evaluation section of the assessment was blank.

A review of the Resident Assessment Instrument (RAI) showed an identified exhibited behaviours that occurred one to three days in the last seven days and the behaviours were not easily altered.

A review of the resident's care plan documented the resident exhibited responsive behaviours and specific interventions. The care plan documented that a re-evaluation of PIECES was completed on September 2017, but there was no documented evidence of a re-evaluation being completed.

On two specified dates during the Resident Quality Inspection, the identified resident was in two separate altercations with other residents.

Observations completed on specified dates, showed the identified resident was seated in a wheelchair and was demonstrating responsive behaviours. Another time the identified resident was found in another area of the home until they were redirected by staff.

In interviews, with five PSWs, they could identify specific behaviours the identified resident exhibited. Two PSW and one RPN stated that they were not aware of any

triggers to the identified resident's behaviours.

During an interview, the PSW Behavioural Support Ontario (BSO) lead stated they believed the identified resident's behaviours had decreased since the resident had a change in condition. They described specific triggers for the identified resident's behaviours.

In an interview RPN BSO lead stated that they had completed an assessment in its entirety for residents referred to their program. They reviewed the identified resident's assessment with the inspector and acknowledged the assessment was incomplete. When asked if any reassessment, evaluation or followup was completed by the BSO team, the RPN BSO lead stated that quarterly they ran the Aggressive Behaviour Score (ABS) scores and compare to previous scores to see if there were any improvement in a resident's behaviours or if the resident needed to be discharged from the program. There were also quarterly meetings held.

When asked about triggers for the identified resident, the RPN BSO lead described triggers for the identified resident's behaviours and specific interventions that could be used to manage the behaviours. The RPN BSO lead acknowledged a gap in communicating this information to the front line staff. They also acknowledged that the identified resident's plan of care had not identified specific strategies to use to address specific behaviours the resident exhibited.

The Regional Manager stated they had a discussion last week with the RPN BSO lead about making behaviour strategies clear and simple and communicating them. When asked if they could demonstrate that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying factors that could potentially trigger behaviours and implementing strategies to minimize these triggers and the risk of altercations, the Regional Manager stated they were planning to do daily huddles, talk about behaviours at every report and they had a drop down huddle in Point Click Care to document but this had not yet been implemented at this home.

The severity of the issue was potential for harm and the scope of the issue was isolated. The home had a history of ongoing non compliance and a compliance order was issued on April 12, 2016 and February 22, 2017. [s. 54.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of three Minimum Data Set Assessments for an identified resident showed changes in the resident's continence status over a specified period.

A review of an identified resident's current care plan related to continence stated to report to the nurse any changes.

During interviews, Assistant Director Of Care/Resident Assessment Instrument (ADOC/RAIC) Registered Nurse and a Personal Support Worker said that the resident's continence status had changed since admission to the home and the identified resident's care plan was not reflecting the current care needs of the resident. Both said that it was the home's expectation that the plan of care was reviewed and revised when the resident's care needs change or care set out in the plan was no longer necessary.

The licensee failed to ensure that an identified resident was reassessed and the plan of

care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

2. An identified resident had a history of falls.

Review of assessments on Point Click Care for the identified resident showed a fall risk assessment (FRAT) identified the resident at risk for falls.

Review of the care plan for the identified resident showed interventions for falls included use of a safety device.

Observations of the identified resident's room did not show evidence of a safety device in use for the resident.

In interviews, three Personal Support Workers (PSW) and a Registered Nurse (RN) could identify interventions used to minimize the risk of falls for the identified resident.

The RN acknowledged the safety device was no longer used for the identified resident. The RN and Assistant Director Of Care/Resident Assessment Instrument (ADOC/RAIC) acknowledged the care plan for the identified resident was not revised when the resident care needs changed.

The severity of the issue was minimum risk and the scope of the issue was isolated. The home had a history of related non-compliance. [s. 6. (10) (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 a resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A review of a Critical Incident for the home stated that the identified resident was allegedly neglected by a staff member and the incident was witnessed by an oncoming staff that day. The oncoming staff, when aware of the alleged neglect did not immediately report the incident to the Executive Director/Director of Care and Director.

During an interview, the Regional Manager of Education and Resident Services, acknowledged that the alleged neglect was not reported immediately and that the home's expectation was to report abuse/neglect immediately to the Director. [s. 24. (1)]

2. (a) A review of the a Critical Incident (CI) report related to possible abuse/neglect of a specified resident on a specified date.

Oncoming staff heard an identified resident yelling; they received report from staff going off shift and when they attended the identified resident they found the resident on the floor.

Approximately four hours later, a Personal Support Worker informed the on call manager, described the incident and requested the on call manager to notify the Director of Care.

During interviews, the on call manager, acknowledged that they had been on call at the time of the incident. They received the information when they returned to work and informed the Director of Care (DOC) at that time.

During interviews the Regional Manager of Education and Resident Services, acknowledged the alleged incident of abuse/neglect was not reported immediately and that the home's expectation was to report abuse/neglect immediately to the Director.

(b) A review of a Critical Incident (CI) for the home, alleged staff to resident abuse. It documented on a specified date that a Registered Practical Nurse (RPN) allegedly abused an identified resident in the home.

Documentation showed the Interim Recreation Services Manager (RSM) heard the incident. They came to the area and spoke to the RPN ; the RSM removed the identified resident from the area. The RSM did not immediately report the incident to the Director.

During an interview, the Regional Manager of Education and Resident Services, acknowledged the alleged incident of abuse/neglect was not reported immediately and that the home's expectation was to report abuse/neglect immediately to the Director. [s. 24. (1)]

3. The home reported a Critical Incident System (CIS) to the Ministry of Health and Long-Term Care on a specified date. The report related to unlawful conduct that resulted in harm/risk of harm to a specified resident. The home completed an investigation.

The documentation showed that the home completed an investigation and issued staff discipline. The documentation also showed that the PSW had reported the incident in writing to the Office Manager on a specified date.

The Critical Incident Report was reviewed by the Regional Manager (RM) with Inspector #213 . The RM agreed that the incident involving the specified resident was not immediately reported to the Director. They said the expectation was that any incident of unlawful conduct or abuse of a resident was to be immediately reported to the Ministry of Health and Long Term Care.

The licensee failed to ensure that a person who has reasonable grounds to suspect that unlawful conduct that resulted in harm or a risk of harm to a resident has occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director.

The severity of the issue was minimal risk and the scope of the issue was isolated. The home had a history of related non-compliance December 12, 2016, and a written notification was issued. [s. 24. (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 a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service; O. Reg. 79/10, s. 90 (2).
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and O. Reg. 79/10, s. 90 (2).
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented to ensure preventative and remedial maintenance.

During observations from a tour of the common areas of the home and of resident rooms it was noted that there was paint chips from the walls of the dining room area and corrosion around the base of toilet in a resident room.

A review of the home's policy #ES E-05 last revised January 21, 2015, stated in part "Preventive maintenance will be carried out on a daily, weekly and monthly basis. A monthly preventative maintenance report will be completed by the Environmental Services Manager or maintenance person and copies forwarded to the Administrator of the home".

A review of the home home's Quality Activities Calendar/Environmental Services Manager schedule for maintenance prevention program was developed, however there were no evidence of implementation or completion of the maintenance program.

During an interview, the Assistant Director Of Care /Resident Assessment Instrument Coordinator stated that they had a conversation with the Administrator that the maintenance program was not implemented and that they be will revising it and will be completed in the future. They stated that the home's expectation was that the maintenance program be developed and implemented.

The severity of the issue was minimal risk and the scope of the issue was isolated. The home had a history of unrelated non-compliance. [s. 90. (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 procedures are implemented for preventative and remedial maintenance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Review of an identified resident's progress notes indicated that the resident was experiencing pain and discomfort from a specified site. A medicated ointment was used but provided little relief. The resident's progress notes and Medication Administration Record (MAR) showed that the resident received two analgesic tablets, 23 times for the discomfort during a five week period.

Review of the home's "Pain Assessment and Management" policy #CARE8-O10.01 last reviewed July 31, 2016, stated in part "Procedure: resident will be screened for pain: move in, new or worsened pain, with change in condition. If the resident answers yes, or shows signs of observed pain, then the nurse will assess for pain using the Pain Assessment Tool and initiate a 72-Hour Pain Monitoring Tool".

A review of the physician's order for the identified resident showed an ointment that could be applied to the pain site as needed; a second ointment was to be applied topically twice a day to the affected area; and analgesic to be given by mouth every four hours as needed for pain.

During an interview, the resident complained of ongoing pain and stated the nurses were aware of the pain.

During an interview, two PSWs, stated that the identified resident had pain and the resident did not sit for a long time due to the pain.

During an interview, the RN said that the identified resident had pain in a specified area and they had given the resident an analgesic in addition to other pain interventions. The RN stated that the resident had a pain assessment completed on admission and no pain assessments were completed after that. The RN said that the home's expectation was that a pain assessment should be completed for residents experiencing pain.

During an interview, the ADOC/RAI Coordinator stated that identified resident was experiencing pain and that no pain assessments were completed for the resident. The ADOC/RAI Coordinator said that the home's expectation was that a pain assessment should be completed for residents experiencing new pain.

The severity of the issue was potential for harm and the scope of the issue was isolated. The home had a history of unrelated non-compliance. [s. 52. (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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy "Nutritional Care and Hydration, Food and Fluid Intake Monitoring" was complied with.

O. Reg. 79/10, s. 68(2)(d) states: every licensee of a long-term care home shall ensure that the nutrition care and hydration program includes a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The Revera policy "Nutritional Care and Hydration, Food and Fluid Intake Monitoring" #Care7-010.02 was reviewed and stated under procedure: "the Unregulated Care Provider (UCP) documents food and fluid intake each shift, as required, including activities and during the night shift. Nurse/delegate will review resident daily food and fluid intake".

Weight loss was triggered from stage 1 of the Resident Quality Inspection related to two identified residents.

The care plan for one identified resident was reviewed and it included that the resident was at nutritional risk as evidenced by their diagnosis and variable intake at meals; the second identified resident was at nutritional risk evidenced by their diagnosis.

A review of Point of Care (POC) documentation for the past 29 days for eating showed that the documentation related to one resident's nutritional intake for 3 meals per day was 41 percent (%); documentation for the second resident related to their nutritional intake for 3 meals per day was 45%.

The POC documentation of food intake for identified residents were reviewed in PCC with the Assistant Director of Care (ADOC) who agreed that the POC documentation showed that there were several meals with the intake not documented for both of these residents in the past 29 days. They said that the expectation was that the food intake was documented for all meals and snacks as well as fluids for all residents every day. The ADOC agreed that the Registered Dietitian (RD) would not be able to complete an accurate assessment of nutritional risks and needs of residents without accurate documentation of the resident's food intake at each meal.

In an interview with the RD, they said that their assessment would include reviewing the

resident's intake and that they had found that several residents in the home had not had the intake for all meals documented every day which made completing an accurate assessment of food and fluid intake difficult.

The licensee failed to ensure that the policy "Nutritional Care and Hydration, Food and Fluid Intake Monitoring" was complied with when all meals were not documented for two identified residents in a 29 day period.

The severity of this issue was minimal harm or potential for actual harm. The scope of the issue was isolated. The home had a history of related non compliance February 19, 2015 and was issued a voluntary plan of correction. [s. 8. (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 the Unregulated Care Provider (UCP) documents the food and fluid intake each shift, as required, including activities and during the night shift. The nurse/delegate will review resident daily food and fluid intake, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).
(e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition

or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence; and that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment.

The home reported a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care related to alleged staff to resident neglect of a identified resident. The report noted that the identified resident required care during meal while in the dining room, was asking for care and that a Registered Practical Nurse (RPN) and Registered Nurse (RN) directed Personal Support Worker (PSW) not to provide care until after the meal was finished. The home completed an investigation.

The Revera policy "Continence Care - Change of Continence" #CARE2-010-01, dated August 31, 2016, stated: "Procedure: The nurse will:
• Initiate the 3 day continence diary with the change in continence status
• Complete a continence assessment (PCC)
• Review the RAPs or CAPS, assessment results and monitoring records
• Review/develop a plan of care if the resident is assessed as incontinent and/or determined a candidate for a continence restorative program
• Determine the appropriate incontinence product based on the resident's individual assessed need."

A record review for the identified resident was completed. It showed the identified resident recently had a change in their continence status. There was no documentation of a continence assessment and there was no documentation of the resident's continence status or care needs in the resident's plan of care.

In an interview with two Personal Support Workers (PSW) , they said that the resident required a containment product and total assistance to provide personal hygiene and change the product when needed.

Inspector #213, the Regional Manager and the Assistant Director of Nursing (ADOC) reviewed the health record for the resident in Point Click Care. The ADOC agreed that there was no continence assessment completed for the identified resident since a change in their continence status and there was no plan of care related to continence for this resident. The RM and the ADOC said that the expectation was that a continence assessment should have been completed and a plan of care developed related to

continence.

The licensee failed to ensure that an identified resident received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence; and that the resident had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment.

The severity of the issue was potential for actual harm and the scope of the issue was isolated. The home had a history of unrelated non-compliance. [s. 51. (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 each resident who is incontinent receives an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence; and that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was documented together with a record of the immediate actions taken to assess and maintain the resident’s health; reviewed and analyzed, corrective action taken as necessary and a written record kept; and that a quarterly review was undertaken of all medication incidents in order to reduce and prevent medication incidents.

Three medication incidents were reviewed in Risk Management in Point Click Care for a specified three month period for three identified residents.

For two of the medication incidents, there was no documentation of an assessment of the resident, the reason for the error, or any analysis or actions taken related related to the medication incidents.

In an interview with the Executive Director/Director Of Care, the ED/DOC agreed that both incidents did not include documentation of assessment of the resident and actions taken to ensure the health of the resident, any analysis of the incidents or any corrective actions taken.

The Inspector requested documentation of the quarterly analysis of medication incidents from the ED/DOC and the Pharmacist. The home was not able to provide documentation of the quarterly analysis of medication incidents and both agreed that a quarterly analysis of all medication incidents was not completed.

The licensee failed to document, together with a record of the immediate actions taken to assess and maintain the resident’s health, review and analyze, and take corrective action as necessary, for medication incidents involving two identified residents. The licensee also failed to complete a quarterly review of all medication incidents in order to reduce and prevent medication incidents.

The severity of the issue was potential for harm and the scope of the issue was a pattern. The home had a history of unrelated non-compliance. [s. 135.]

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 medication incident involving a resident is documented together with a record of the immediate actions taken to assess and maintain the resident's health, reviewed and analyzed, corrective action taken as necessary and a written record kept; and that a quarterly review is undertaken of all medication incidents in order to reduce and prevent medication incidents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

The home reported a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care, related to alleged staff to resident neglect of an identified resident. The report noted that the resident required care during the meal while in the dining room, was asking for care and the Registered Nurse (RN) and Registered Practical Nurse (RPN) directed a Personal Support Worker (PSW) not to provide care until after the meal was finished. The home completed an investigation.

A review of the Critical Incident Report showed the last the amendment to the report did not include the results or outcome of the investigation including actions taken related to staff discipline or education completed.

The Critical Incident Report was reviewed by the Regional Manager (RM) with the

inspector. The RM agreed that the Critical Incident Report was not amended with the results of the investigation. They said the expectation was that the management of the home completes an immediate investigation and then reports the results of the investigation to the Director via the CIS reporting system.

2. The home reported a Critical Incident System (CIS) report related to unlawful conduct that resulted in harm/risk of harm to a specified resident. The report stated that a Personal Support Worker (PSW) reported that Registered Practical Nurse (RPN) restrained the resident to apply a safety device. The home completed an investigation.

The Critical Incident Report was not amended after the initial submission that included the results or outcome of the investigation including actions taken related to staff discipline or education completed.

The Critical Incident Report was reviewed by the Regional Manager (RM) with the inspector. The RM agreed that the CIS report was not amended with the results of the investigation. They said the expectation was that the management of the home completes an immediate investigation and then reports the results of the investigation to the Director via the CIS reporting system.

The severity of the issue was minimal risk and the scope of the issue was isolated. The home had a history of unrelated non-compliance. [s. 23. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was created and maintained for one resident of the home.

On a specified date a physically aggressive incident occurred between two identified residents without injury. One resident was uncooperative and refused administration of medication. The resident was transferred to hospital for assessment and returned to the home on the same date.

On return to the home, a Responsive Behaviour Huddle Assessment was completed and specific interventions were initiated for the specified resident as well as a referral to the Behavioural Support Ontario (BSO) team. The care plan for the identified resident was reviewed and revised to include the new behaviour interventions.

On another specified date, a second physically aggressive incident occurred between the two specified residents resulting in injury to the second resident. The first resident was uncooperative, was administered medication and admitted to hospital for assessment.

The Executive Director/Director Of Care (ED/DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), RN, Registered Practical Nurse/Behaviour Support Ontario (RPN/BSO) Lead, two Personal Support Worker (PSW) shared with the Inspector that DOS charting is completed by PSW staff on a paper document.

Two RN, RPN/BSO Lead, and two PSW said to the Inspector that Dementia Observational Screening (DOS) charting was initiated by PSW's for the first identified resident between for a specified one week period.

During review of the clinical record for the first identified resident, DOS charting was not available.

The ED/DOC, ADOC and RPN/BSO Lead were not able to locate the DOS documentation that they identified as completed for resident.

The home failed to ensure that a written record was created and maintained for one resident of the home.

The severity of the issue was minimal risk and the scope of the issue was isolated. The home had a history of unrelated non-compliance. [s. 231. (a)]

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

---

Issued on this 17th day of October, 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) :	JANETM EVANS (659), CAROLEE MILLINER (144), HELENE DESABRAIS (615), RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2017_363659_0021
Log No. / No de registre :	021094-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 12, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	PINECREST MANOR 399 BOB STREET, P.O. BOX 220, LUCKNOW, ON, N0G-2H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Helen Bechard

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

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

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_0030, 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 home shall prepare, submit and implement a plan to ensure that for the identified resident and any other resident exhibiting responsive behaviours, that steps are taken to minimize the risk of alterations 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 to minimize the risk of altercations between residents.

The plan shall also include a method to track information related to residents who are exhibiting responsive behaviours and which persons are responsible to ensure that the information related to residents who are exhibiting responsive behaviours is communicated to staff.

Please submit the plan, in writing, to Janet Evans, Long Term Care Home Inspector, Ministry of Health and Long Term Care, Long Term Care Inspections Branch, 130 Dufferin Avenue, 4th floor, London, ON N6A 5R2, by email, at Janet.Evans@ontario.ca by November 2, 2017.

Grounds / Motifs :

1. The licensee had 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 an interdisciplinary assessment and on information provided to the licensee or staff or through observations, that could potentially trigger such altercations; and
(b)identifying and implementing interventions.

This inspection was completed as follow up to compliance order #001 from Resident Quality inspection # 2016_325568_0030, issued February 22, 2017, to be complied by April 30, 2017. The compliance order was previously issued from inspection #2016_325568_007 served on April 13, 2016.

The compliance order stated that the licensee shall ensure that for the identified resident and any other resident exhibiting responsive behaviours, that steps are taken to minimize the risk of alterations 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.

1. The licensee had 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 an interdisciplinary assessment and on information provided to the licensee or staff or through observations, that could potentially trigger such altercations; and
(b)identifying and implementing interventions.

A review of the clinical record for an identified resident showed incidents where the resident exhibited specific responsive behaviours.

A Behaviour Support Ontario (BSO) referral had been initiated November 2016, for the identified resident's behaviour.

A Physical, Intellectual, Emotional, Capabilities, Environment and Social (PIECES) assessment was reviewed which identified environmental triggers affecting the residents behaviours. There was no follow up or plan documented related to the assessment. The evaluation section of the assessment was blank.

A review of the Resident Assessment Instrument (RAI) showed an identified exhibited behaviours that occurred one to three days in the last seven days and the behaviours were not easily altered.

A review of the resident's care plan documented the resident exhibited responsive behaviours and specific interventions. The care plan documented that a re-evaluation of PIECES was completed on September 2017, but there was no documented evidence of a re-evaluation being completed.

On two specified dates during the Resident Quality Inspection, the identified resident was in two separate altercations with other residents.

Observations completed on specified dates, showed the identified resident was seated in a wheelchair and was demonstrating responsive behaviours. Another time the identified resident was found in another area of the home until they were redirected by staff.

In interviews, with five PSWs, they could identify specific behaviours the identified resident exhibited. Two PSW and one RPN stated that they were not aware of any triggers to the identified resident's behaviours.

During an interview, the PSW Behavioural Support Ontario (BSO) lead stated they believed the identified resident's behaviours had decreased since the resident had a change in condition. They described specific triggers for the identified resident's behaviours.

In an interview RPN BSO lead stated that they had completed an assessment in its entirety for residents referred to their program. They reviewed the identified resident's assessment with the inspector and acknowledged the assessment was incomplete. When asked if any reassessment, evaluation or follow up was completed by the BSO team, the RPN BSO lead stated that quarterly they ran the Aggressive Behaviour Score (ABS) scores and compare to previous scores to see if there were any improvement in a resident's behaviours or if the resident needed to be discharged from the program. There were also quarterly meetings held.

When asked about triggers for the identified resident, the RPN BSO lead described triggers for the identified resident's behaviours and specific interventions that could be used to manage the behaviours. The RPN BSO lead

acknowledged a gap in communicating this information to the front line staff. They also acknowledged that the identified resident's plan of care had not identified specific strategies to use to address specific behaviours the resident exhibited.

The Regional Manager stated they had a discussion last week with the RPN BSO lead about making behaviour strategies clear and simple and communicating them. When asked if they could demonstrate that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying factors that could potentially trigger behaviours and implementing strategies to minimize these triggers and the risk of altercations, the Regional Manager stated they were planning to do daily huddles, talk about behaviours at every report and they had a drop down huddle in Point Click Care to document but this had not yet been implemented at this home.

The severity of the issue was potential for harm and the scope of the issue was isolated. The home had a history of ongoing non compliance and a compliance order was issued on April 12, 2016 and February 22, 2017. [s. 54.] (659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 12, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

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