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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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
Mar 20, 2018	2018_531659_0004	024296-17	Follow up

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 7 and 8, 2018.

The following intakes were:
Log # 024296-17 Follow up to Compliance Order #001 related to responsive behaviours.
Log # 003117-18\2600-000002-18 Critical Incident related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with Regional Director of Clinical Operations, Regional Manager Clinical Services, Interim Director of Care, Assistant Director of Care, Education Coordinator, Registered Nurses, Registered Practical Nurses, Behaviour Support Personal Support Worker, Personal Support Workers, Dietary Aide, Activity Aide, Southwest Community Care Access Care Coordinator, a resident and family member.

Observations were completed of resident to resident and staff to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 54.	WN	2017_363659_0021	659
O.Reg 79/10 s. 54.	CO #001	2017_363659_0021	659

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. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

On a specified dated an identified resident was sent to hospital for assessment and was discharged to return to the home the same day.

In an interview, the Substitue Decision Maker (SDM) for the identified resident received a call from the home and were informed the identified resident could not return to the home.

In an interview Assistant Director of Care (ADOC), stated the Regional Director (RD), told them not to accept the identified resident back to the home. The ADOC stated they called the Substitute Decision Maker (SDM) for the identified resident and told the SDM they could not have the identified resident in the building at this time.

The ADOC acknowledged they had not contacted Community Care Access Center (CCAC) about the discharge, to initiate assistance with alternate accommodations and services, rather CCAC had contacted the home on a specified date after the SDM had spoken with them.

In an interview, South West CCAC Care Coordinator (CC) stated that they had received a telephone call on a specified date from the SDM regarding the discharge of the resident from the nursing home. Later on the specified date CCAC received a telephone call from the RD to say the home came to a decision to discharge the identified resident.

The licensee has failed to ensure that before discharging a resident under subsection 145 (1) (the resident's requirements for care have changed and as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident) specifically the licensee did not (a) ensure that alternatives to discharge have been considered and, where appropriate, tried; (b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident. [s. 148. (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 the licensee shall ensure that before discharging a resident they (a) ensure that alternatives to discharge have been considered and, where appropriate, tried; (b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; (c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and (d) provided a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an identified resident was protected from abuse by anyone.

This inspection was completed as a result of critical incident reported to the Ministry of Health which alleged a resident to resident abuse.

In 2018 an incident occurred in which one resident was injured, required further assessment and treatment.

Review of the clinical record for the resident with identified behaviours showed the Resident Assessment Instrument assessment (RAI) documented the resident did not have any indicators of low mood or responsive behaviours.

Review of "behaviour report" on Point Click Care (PCC) did not show documented responsive behaviours.

Review of progress notes on PCC showed incidents of verbal aggression to staff or refusal of assistance with care.

An assessment of the identified resident completed by the Southwest Community Care Access Centre (CCAC) prior to their admission to the home documented the identified resident did not have a known history of physical or verbal responsive behaviours.

During interviews, staff shared that there were no previous behaviours demonstrated by the resident. One staff member said that at times the resident could demonstrate a certain trait however, they appeared to get along with the other resident involved.

In interviews Assistant Director of Care (ADOC) stated the identified resident was a private and independent individual and that they did not want to accept assistance; on occasion the resident could demonstrate a certain behaviour toward staff.

The Regional Director (RD) stated the resident injured in the altercation was fearful.

The licensee failed to protect an identified resident from abuse by anyone which alleged a resident to resident altercation. [s. 19. (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 all residents of the home are protected from abuse by anyone., to be implemented voluntarily.

Issued on this 28th day of March, 2018

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

Original report signed by the inspector.