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 prévue 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
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 09, 2019	2019_792659_0020 (A1)	004649-19, 014430-19, 015230-19	Complaint

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

Amended by JANETM EVANS (659) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

No amendment to Public report was required. Amendment to Licensee report completed for finding under s. 101 (2) the last two lines were removed.

Issued on this 9 th day of October, 2019 (A1)

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

Ministère de la Santé et des Soins de longue durée

Inspection Report under *the Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue 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
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 09, 2019	2019_792659_0020 (A1)	004649-19, 014430-19, 015230-19	Complaint

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

Amended by JANETM EVANS (659) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 3, 4, 5 and 6, 2019.

The following intakes were included as part of the inspection

Log #004649-19\Complaint related to care concerns and possible neglect of a resident.

Log #014430-19\Critical Incident #2600-000015-19 related to possible abuse of a resident by staff.

Log #015230-19\Critical Incident, IL-68974-AH/2600-000016-19 related to resident to resident altercation.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), RAI Coordinator (RAI-C), Nutrition Manager, Education Coordinator, Behavioural Support Ontario staff (BSO), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Cooks, Housekeeping and residents.

Observations were made of medication administration, provision of care, staff to resident interactions, resident to resident interactions, general cleanliness of the building and furnishings.

The following Inspection Protocols were used during this inspection:

Dining Observation
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put any procedure in place, the procedure was complied with.

In accordance with LTCHA, s.11(2) and in reference to O.Reg.79/10 s. 73 (6), the licensee was required to ensure that residents were provided with food and fluids that were served at a temperature that was both safe and palatable to the residents. Specifically, staff did not comply with the licensee's policy LTC-Food Temperature Checklist, dated March 31, 2019, as part of their nutrition care and dietary services program which stated that the cook/food service worker takes the temperatures of the menu items for all diet types and textures and immediately after records this on the Meal Service Daily Temperature Record. All menu items were to be served in the acceptable standard temperature range and if temperatures were not within standard range, action must be taken and recorded.

A complaint was submitted to the MLTC which alleged that an identified resident was fed a meal that was too hot on a specified date.

The home's investigation documented that an identified staff member said there had been steam coming off the meal and the resident's table was one of the first served.

The identified staff member recalled that they had taken the temperature of the meal prior to it being served to residents. They stated they saw the identified resident turn their head away as a PSW tried to feed them and they wondered if the food was too hot for the resident.

The Daily Temperature log was reviewed for a specified date for two meals. It showed that the log had been left blank; temperatures were not documented.

The Nutrition Manager stated that food temperatures were supposed to be taken prior to serving food to residents, and they acknowledged that the temperature of two meals had not been recorded on a specified date.

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put any procedure in place, the procedure was complied with. Specifically they failed to ensure that to documentation of food temperatures were recorded along with actions taken to adjust the temperature of the food as needed, in order to ensure that food was served at a temperature that would be safe and palatable for residents. [s. 8. (1) (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 the temperature for each cooked food will be taken at each meal and documented. If temperatures are not within the standard range, action will be taken and recorded prior to the meal being served to residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, specifically related to immediate reporting of alleged or suspected abuse.

A Critical Incident System report was received by the Ministry of Long Term Care (MLTC) on a specified date, which alleged abuse of a resident.

The home's Resident Non-Abuse Program, ADMIN1-P10-ENT, dated March 31, 2019, stated that "Anyone who becomes aware of or suspects abuse or neglect of a Resident must immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on shift".

An identified staff stated they reported the incident in question to the Executive Director the day following the alleged incident, and acknowledged they had not immediately reported the incident of suspected abuse.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, specifically related to immediate reporting of alleged or suspected abuse. [s. 20. (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 staff are aware of the home's requirement to ensure that all witnessed, suspected or alleged abuse is immediately reported to the Executive Director or most senior supervisor on the shift, to be implemented voluntarily.

WN #3: 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 has failed to ensure that a documented record was kept in the home that included:
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, and any follow-up action required
(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

A complaint was received by the MLTC which stated that there had been unresolved complaints related to an identified resident's care and the home had not provided an explanation of what was done to address some complaints.

Review of complaint records for 2019 related to the identified resident showed documentation of five Client Services Response forms (CSR) by the home during a six month period. In addition to this, there were two face to face meetings documented.

Review of the complaints documentation showed in one instance, the date the complaint/concern was received was not recorded; in one instance the date on which any response was provided to the complainant was not recorded and in one instance there did not appear to be any documented follow up related to the identified complainant concerns.

Meeting minutes listed 26 concerns to be addressed; who was responsible for the resolution and the target date for the resolution. At the time of review, 13 of the items were documented as completed or notifications done. Minutes from a second meeting, documented 14 prior concerns and added five new concerns. On the bottom of the form there was documentation that the complainant was offered another meeting with the home and declined. There was no documentation related to the actual date of the action; the final resolution if any, was not documented in all instances; there was no documentation to indicate every date on which any response was provided to the complainant, a description of the response provided or any response made in turn by the complainant. In some instances just a check mark would be seen beside the resolution/by whom or target date.

The DOC reviewed complaints relating to the identified resident, with Inspector. They acknowledged that not all items listed from the concerns had been signed off as completed or resolved, particularly related to the two face to face meetings. The DOC stated that in some instances the concerns were ongoing but they believed most of the concerns had been addressed by the home.

The licensee failed to ensure that a documented record was kept in the home that included:
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, and any follow-up action required
(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. [s. 101. (2)]

Issued on this 9 th day of October, 2019 (A1)

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

Original report signed by the inspector.