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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 12, 2014	2014_360111_0024	O-000656-14	Follow up

Licensee/Titulaire de permis

MEDLAW CORPORATION LIMITED
42 Elgin Street, Thornhill, ON, L3T-1W4

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

PINECREST NURSING HOME (2731)
3418 County Road 36, R.R. #2, BOBCAYGEON, ON, K0M-1A0

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

LYNDA BROWN (111)

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): September 29 & 30, 2014

2 Complaints (log#000947 & 000912) and 1 critical incident (log#000451) was completed concurrently during this follow-up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), residents, Registered Nurse(RN), Registered Practical Nurses(RPN),Personal Support Workers(PSW), Behaviour Support Ontario (BSO) Team

During the course of the inspection, the inspector(s) observed residents, reviewed health care records of residents, reviewed staff training records,investigations,employee records, staffing schedules, and the home's policy on Prevention of Abuse and Neglect & Responsive Behaviours.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 residents were protected from verbal and physical abuse by a staff member in the home.

Physical abuse is defined under O.Reg.79/10, s. 2(1) "physical abuse" (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Verbal abuse is defined under O.Reg.79/10, s.2(1) " verbal abuse" (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Related to log# 000451:
A Critical incident report (CIR) was submitted by the home on a specified date for a improper treatment of a resident by a staff member that occurred the day before the CIR was submitted. The CIR indicated that PSW #2 observed PSW#1 rough handling Resident #1 during a transfer resulting in pain and injury to Resident #1. PSW#2 reported the incident immediately to the RN and then reported the incident to the DOC the following day. The CIR indicated PSW#1 had a history "rushing residents with care and rough handling" The CIR indicated that police and POA were notified and PSW#1 was terminated as a result.

Interview of the DOC and review of the home's investigation indicated PSW#2 immediately reported the incident of staff to resident rough handling towards Resident #1 by PSW #1 resulting in injury to the resident to the RN.The RN provided treatment to the resident but did not document the incident as reported and did not complete an incident report until the following day. The RN failed to notify the DOC/Administrator, the POA, police and MOHLTC.PSW#1 had received prior "verbal warnings" regarding verbal abuse and rough handling of residents and was terminated as a result. The RN received disciplinary action as a result of failing to follow the home's policy on prevention of abuse and neglect.

Review of PSW#1 employee record indicated the staff member received a verbal warning on a specified date for reports by co-workers of "rough handling of residents" and "bossy towards residents". PSW#1 received a second verbal warning five months later for reports of "improper care" and "verbal abuse" as PSW#1 had used degrading language and improperly transferred a resident resulting in the resident falling and sustaining pain. PSW#1 received a third "verbal warning"five months later regarding 2 incidents (11 days apart) of improper treatment of a resident. The first incident PSW#1 was heard by another staff member "scolding the resident" and then using "physical force pushing and pulling the resident" leaving the resident "frightened and upset and attempting to free self". The second incident PSW#1 was seen again "rough" with the same resident (11 days earlier) and the resident "expressed fear" of PSW#1. It was after this incident when the warning letter was provided.

A Compliance Order was issued on June 3, 2014 under LTCHA, 2007, s.19 during inspection 2014_220111_0011 with a compliance date of July 4, 2014. [s. 19. (1)]

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 home's written policy that promotes zero tolerance of abuse and neglect of resident's, is complied with.

Related to log#000451:

A Critical incident report (CIR) was submitted by the home on a specified date for a improper treatment of a resident by a staff member that occurred the day before the CIR was submitted. The CIR indicated that PSW #1 was assisting PSW #2 with a transfer to Resident #1 when PSW #2 observed PSW#1 rough handling the resident, the resident screamed and sustained an injury. PSW#2 reported the incident immediately to the RN.

Review of the home's policy "Prevention of Abuse and Neglect" indicated on page 5 The Registered Nurse:
-will complete the incident investigation form for every report of alleged, suspected or witnessed abuse of a resident ,
-notify the DOC or Administrator immediately,
-speak to the alleged perpetrator and ask them about the incident & speak to witnesses about what they observed
-document on incident report and provide factual information with as much detail as possible, including time , place, individuals involved, factors leading to situation, actions taken
-ask witness to complete a written statement using the Resident Abuse Allegation

/Investigation Witness Report
-ask the alleged perpetrator to complete the Resident Abuse Allegation Report Statement.

Review of the progress notes, interview of the DOC and review of the home's investigation for Resident #1 indicated:
-PSW#2 immediately reported to the RN (in charge) a witnessed incident of staff to resident rough handling during a transfer resulting in pain and injury towards Resident #1 by PSW#1.
-the RN did not document the incident (until the following day) and did not indicate it was a late entry, when the incident occurred, and what actions were taken as a result. The RN did not notify the DOC/Administrator, complete the incident report form, and did not obtain statements from witnesses.
- the DOC received a report from PSW#2 of rough handling of Resident #1 resulting in an injury the day after the incident occurred. The DOC documented the incident at that time, completed the incident report form, notified the Administrator, notifyied the MOH, OPP and family as per our policy.
- when PSW#2 immediately reported the incident to the RN, PSW#2 requested the appropriate forms to be completed as per the home's policy and was informed by the RN "didn't know what forms" and no forms were provided.

A Compliance Order was issued on June 3, 2014 under LTCHA, 2007, s.19 [which included s. 20(1)]during inspection 2014_220111_0011 with a compliance date of July 4, 2014. [s. 20. (1)]

WN #3: 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. Related to log #000451:

The licensee has failed to ensure that when a person had reasonable grounds to suspect that improper or incompetent treatment of a resident occurred that resulted in harm, was immediately reported to the Director.

Review of the progress notes, interview of the DOC and review of the home's investigation for Resident #1, indicated the RN (who was in charge) on a specified date was notified by PSW#2 that PSW#1 was rough handling Resident #1 during a transfer. Resident#1 sustained an injury and pain as a result. The RN did not did not report the incident to anyone and did not document the incident until the day after the incident occurred.

The RN had reasonable grounds to suspect improper care and did not report the incident to the Director.

A Compliance Order was issued on June 3, 2014 under LTCHA, 2007, s.19 [which included s. 24(1)]during inspection 2014_220111_0011 with a compliance date of July 4, 2014. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. Related to log #000451:

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of a witnessed incident of improper care of a resident that resulted in physical injury and pain to the resident.

A Critical incident report (CIR) was received on a specified date for a staff to resident physical abuse incident that occurred the day before. The CIR indicated that Resident #1 was being transferred by two PSW's. One PSW grabbed Resident #1 roughly resulting in pain and injury.

Interview of the DOC indicated the PSW witnessing the incident, reported the incident to the RN but the RN did not notify the SDM. The DOC indicated she notified the SDM the following day when PSW#2 reported the incident to the DOC.

A Compliance Order was issued on June 3, 2014 under LTCHA, 2007, s.19 [which included s. 97(1)(a)]during inspection 2014_220111_0011 with a compliance date of July 4, 2014. [s. 97. (1) (a)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_220111_0011	111

Issued on this 12th day of November, 2014

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