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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 3, 2016	2016_339617_0012	007325-16	Complaint

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive KENORA ON P9N 2W7

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

PINECREST
1220 VALLEY DRIVE KENORA ON P9N 2W7

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

SHEILA CLARK (617)

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): April 25, 26, 27, 28, 29, 2016.

This Complaint inspection is related to the following two complaints regarding:
- plan of care, skin and wound, continence care, resident's rights, infection control,
- continence care, duty to protect..

This inspection was conducted concurrently with Follow Up Inspection #2016_339617_0014 and Critical Incident Inspection #2016_339617_0011.

Findings of non-compliance regarding mandatory reporting, LTCHA, 2007, S. O. 2007, c. 8, s. 20 (1), and s. 23 (2), found the Critical Incident Inspection #2016_339617_0010, were issued in this report.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), Human Resources Manager (HRM), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Housekeepers (HSKs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), residents and family.

Observations were made of the home areas, meal services, and the provision of care and services to residents during the inspection. the home's policy and procedures, resident health records and staff training and personnel records were reviewed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this 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	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. 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 in place to promote zero tolerance of abuse and neglect of residents regarding mandatory reporting was complied with.

A Critical Incident (CI) report regarding staff to resident abuse was submitted from the home to the Director five days after the incident occurred.

A review of the CI report described several meetings and complaints from resident #005's Substitute Decision Maker (SDM) regarding resident #005 being rough handled and care concerns.

A complaint was also submitted to the Director by resident #005's SDM, reporting that staff rough handled the resident during care.

Inspector #617 interviewed both the SDM and resident #005 who reported that staff rough handled the resident during care. Resident #005 stated that they reported the incident to the Registered Nurse (RN) when the incident occurred.

A review of resident #005's progress notes confirmed that the CI was reported to the RN on the date it occurred.

The home conducted an investigation regarding the CI report and a review of those notes confirmed that the incident did occur five days before the home reported it to the Director.

Inspector reviewed the home's policy titled "Zero Tolerance of Abuse and/or Neglect -

ADM 450" last updated on June 2015, which indicated that staff must report all alleged, suspected or witnessed incidents of abuse of a resident by anyone and neglect of a resident by a staff member of the home. When a manager/designate or other received an internal report from an employee on a suspected or alleged, or actual incident of abuse or neglect, they would immediately report to the MOHLTC by using the Critical Incident System.

Inspector interviewed the DOC who confirmed that the RN was expected to immediately report the CI that occurred involving resident #005 to the DOC and did not. The DOC confirmed that they were available on their cell phone during the time of the CI to take the call.

2. A CI report of staff to resident verbal abuse was reported to the Director two days after the CI actually occurred.

A review of the home's investigation notes indicated that a staff member witnessed a member of the registered staff verbally abuse resident #004 during the medication pass. The alleged verbal abuse triggered resident #004 to have responsive behaviours. The staff member who witnessed the CI reported the incident to the DOC two days after the CI actually occurred resulting in the home submitting the CI report to the Director late.

The Inspector interviewed the DOC who confirmed that the staff member who witnessed the CI was expected to immediately report the CI that occurred involving resident #004 to the registered nurse (RN) on duty and did not. The RN would then be responsible to complete an incident report and immediately report to the DOC who was available on their cell phone during the time of the CI.

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 written policy in place to promote zero tolerance of abuse and neglect of residents regarding mandatory reporting will be complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 their investigation into the Critical Incident undertaken under clause (1) (a) regarding resident abuse was reported to the Director.

A CI report and a complaint was received by the Director regarding resident #005 who was allegedly rough handled by staff during care provision.

A review of the home's policy titled "Zero Tolerance of Abuse and/or Neglect - ADM 450" revised June 2015, indicated that management staff would report to the MOHLTC Director the results of every investigation the home conducted under this policy and any action the home took in response to any incident of resident abuse or neglect.

A review of the home's internal investigation regarding the CI in which resident #005, staff and the SDM were interviewed, determined that physical abuse did not occur by two staff members during care of the resident.

On April 28, 2016, the Inspector reviewed the CI reporting system and the home had not reported the results of their investigation into the alleged abuse of resident #005.

On April 29, 2016, the Inspector interviewed the DOC who confirmed that the home failed to report the conclusion of their investigation that abuse did not occur and amend the CI to the Director.

2. A CI report of staff to resident abuse was reported to the Director which indicated that a staff member witnessed a member of the registered staff verbally abuse resident #004 during a medication pass. The alleged verbal abuse triggered resident #004 to have responsive behaviours.

A review of the home's internal investigation regarding the CI in which staff and resident #004 were interviewed, determined that verbal abuse did not occur.

On April 27, 2016, the Inspector reviewed the CI reporting system and the home had not reported the results of their investigation into the alleged abuse of resident #004.

On April 29, 2016, inspector interviewed the DOC who confirmed that the home failed to report the conclusion of their investigation that abuse did not occur and amend the CI to the Director.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the results of every investigation undertaken under clause (1) (a) will be reported to the Director, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006 who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

A written complaint regarding the improper provision of care for resident #006 was received by the Director.

Resident #006's health care record indicated that they were admitted to the home with multiple medical issues and required the use of a specific device.

A review of resident #006's Resident Assessment Instrument Minimal Data Set (RAI-MDS) and care plan both indicated that the resident was incontinent.The Inspector was not able to find a continence assessment completed for resident #006.

Inspector #617 reviewed the home's policy titled "Continence Care and Bowel Management Program - NUR 210" revised June 2014, which indicated that registered nursing staff were responsible to collaborate with the Resident/Substitute Decision Maker (SDM), family and interdisciplinary team to conduct a bowel and bladder continence assessment, Continent Assessment Note (PN-CO) on admission. The PN-CO would include the identification of the causal factors, patterns, type of incontinence, medication and potential to restore function and identify type and frequency of physical assistance necessary to facilitate toileting.

The Inspector interviewed a member of the registered staff who reported that it was the policy of the home to complete the PN-CO for resident #006 within seven days of admission to determine their incontinence care provision. The registered staff reviewed resident #006's health care record and was not able to find a completed continence assessment and then confirmed that resident #006's admission checklist was not checked off as completed for the PN-CO.

On April 28, 2016, the Inspector interviewed the DOC who confirmed that the continence assessment (PN-CO) was not completed for resident #006 and should have been completed by the registered staff as per home's policy. [s. 51. (2) (a)]

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Issued on this 16th day of June, 2016

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

Original report signed by the inspector.