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 le Loi de 2007 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 East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 05, 2018;	2018_643111_0008 (A1)	008853-18	Critical Incident System

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 (Bobcaygeon)
3418 County Road 36, R.R. #2 BOBCAYGEON ON K0M 1A0

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

Amended by LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

To Administrator/DOC,
Further to our telephone conversation, the compliance date to CO #001 for s.6(7) under the LTCA will be extended to May 31, 2018.
Please see the amended report and orders.
thanks
Lynda Brown

Issued on this 5 day of June 2018 (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

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

Amended by LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 2 and 3, 2018

Critical Incident inspection:Log # 008853-18 related to fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurse (RPN), and Personal Support Workers (PSWs).

During the course of the inspection, the inspector reviewed the health care record of a resident who was not in the home, observed the resident's room and reviewed staff training records.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Related to Log # 008853-18:

A critical incident report (CIR) was submitted to the Director on a specified date for a fall incident that caused an injury for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The CIR indicated on a specified date and time, resident #001 was assisted to the toilet by PSW #101 and then left on the toilet unsupervised. The resident subsequently fell to the floor resulting in specified injuries to specified areas. The resident was transferred to the hospital for assessment and diagnosed with specified injuries.

Review of the current written plan of care, for resident #001 indicated, the resident required staff assistance with toileting and was at risk for falls. The plan of care included a number of falls prevention interventions which included constant supervision with toileting.

In an interview with RPN #100 by Inspector #111 on a specified date, indicated that on a specified date and time, PSW #102 reported that resident #001 had sustained a fall. The RPN indicated that they found the resident on the floor with specified injuries to specified areas. The RPN indicated the resident was assigned to PSW #101. The RPN indicated PSW #101 reported the resident was placed on the toilet and then left unattended when the resident fell.

In an interview with PSW #101 by Inspector #111, on a specified date, indicated that they were assigned to provide care to resident #001 on a specified date. The PSW indicated at a specified time, they assisted the resident #001 with toileting and then left the resident unsupervised. PSW #101 indicated they were not familiar with resident #001's toileting needs.

In an interview with the DOC by Inspector #111, on a specified date, indicated resident #001 remained in the hospital, with specified injuries to specified areas. The DOC indicated resident #001's written plan of care indicated the resident was at risk for falls and was to be constantly supervised with toileting. The DOC indicated the expectation is that all PSWs are familiar with the resident's care requirements prior to providing care.

During an interview with the Administrator by Inspector #111, on a specified date, indicated resident #001 had passed away a number of days after the incident.

The licensee failed to ensure that care was provided to resident #001 according to the resident's plan of care related to toileting needs, resulting in the resident sustaining injuries and subsequently died.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

Issued on this 5 day of June 2018 (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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by LYNDA BROWN (111) - (A1)

Inspection No. / No de l'inspection : 2018_643111_0008 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 008853-18 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jun 05, 2018;(A1)

Licensee / Titulaire de permis : Medlaw Corporation Limited
42 Elgin Street, Thornhill, ON, L3T-1W4

LTC Home / Foyer de SLD : Pinecrest Nursing Home (Bobcaygeon)
3418 County Road 36, R.R. #2, BOBCAYGEON, ON, K0M-1A0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Mary Carr

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

Ministère 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

To Medlaw Corporation Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s.6(7) of the LTCHA.

Specifically, the licensee shall ensure:
a) The toileting needs of all residents are provided according to their assessed needs.
b) All direct care staff are aware of any residents toileting needs prior to performing the residents toileting, by reviewing the residents written plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Related to Log # 008853-18:

A critical incident report (CIR) was submitted to the Director on a specified date for a fall incident that caused an injury for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The CIR indicated on a specified date and time, resident #001 was assisted to the toilet by PSW #101 and then left on the toilet unsupervised. The resident subsequently fell to the floor resulting in specified injuries to specified areas. The resident was transferred to the hospital for assessment and diagnosed with specified injuries.

Review of the current written plan of care, for resident #001 indicated, the resident required staff assistance with toileting and was at risk for falls. The plan of care included a number of falls prevention interventions which included constant supervision with toileting.

In an interview with RPN #100 by Inspector #111 on a specified date, indicated that on a specified date and time, PSW #102 reported that resident #001 had sustained a fall. The RPN indicated that they found the resident on the floor with specified injuries to specified areas. The RPN indicated the resident was assigned to PSW #101. The RPN indicated PSW #101 reported the resident was placed on the toilet and then left unattended when the resident fell.

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During an interview with the Administrator by Inspector #111, on a specified date, indicated resident #001 had passed away a number of days after the incident.

The licensee failed to ensure that care was provided to resident #001 according to the resident's plan of care related to toileting needs, resulting in the resident sustaining injuries and subsequently died.

The severity of this issue was a level 4 as there was actual harm to the resident as the resident died. The scope was level 1 as there was only one resident involved. Compliance history was a level 4 as there was related non-compliance issued under LTCHA, 2007, s.6 and also included:
• Written Notification (WN) under s. 6(7) of the LTCHA, October 3, 2016,

(#2016_328571_0028). (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

May 31, 2018(A1)

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

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

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

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 5 day of June 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by LYNDA BROWN - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Central East