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
Sep 18, 19, 2013	2013_049143_0047	O-000217-13	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 (2731)
3418 County Road 36, R.R. #2, BOBCAYGEON, ON, K0M-1A0

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 16th-17th, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, a Registered Practical Nurse and a resident.

During the course of the inspection, the inspector(s) reviewed two resident health care records inclusive of plan of cares, assessments, physician orders and assessments, reviewed resident abuse policies and procedures as well as completed a tour of the nursing home.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Dignity, Choice and Privacy

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 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. Ontario Regulation 79/10 made under the Long Term Care Homes Act, 2007 defines sexual abuse as any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.
On a specified date Resident #2 was sexually abused by resident #1 (non consensual touching). A review of the Pinecrest Policy: Prevention of Abuse and Neglect page 19 -23 indicated that the Resident Abuse Allegation Report Form Part A and Part B is required to be completed by the Receiving Supervisor/RN. On September 16th, 2013 a request was made by the inspector to review these report forms. The Inspector was advised by the Director of Nursing that these forms had not been used as per the homes policies and procedures.
The licensee has failed to comply with the Long Term Care Homes Act section 20. (1) by not ensuring that the written policy to promote zero tolerance of abuse and neglect is complied with. [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 the home's abuse policy and procedure is complied with including completing resident abuse allegation report forms, notifying the resident substitute decision maker, police notification as well as notifying the Ministry of Health and Long Term Care within the regulated time frames, to be implemented voluntarily.

WN #2: 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. On a specified date S101(Registered Practical Nurse) observed the following: Resident #1 was observed sitting beside Resident #2. S101 reported that she/he observed resident #1 touching resident #2. This touching was of a non-consensual sexual nature. S101 had resident #1 removed. S101 reported to the inspector on September 16, 2013 resident #2 appeared frightened and scared and that later in the day was upset. A review of the health care record indicated that a second incident (same nature and circumstances) of sexual abuse occurred between these same residents on a specified date. Resident #1 was removed from the area. Resident #2 was assessed by an attending physician and found to have no physical injuries as a result of this incident. On a specified date S103(Director of Nursing) reported the incident of abuse to the resident's substitute decision-maker (SDM). The SDM was notified five days following the first incident of abuse and three days following the second incident.
The Licensee has failed to comply with Ontario Regulation 97.(1)(b) by failing to notify the resident's SDM within 12 hours upon becoming aware of a witnessed incident of abuse. [s. 97. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. On a specified date Resident #2 was sexually abused by Resident #1. This abuse involved touching of a sexual nature that was non-consensual. Resident #1 was removed from the area. S101 (RPN) reported that resident #2 appeared frightened and later in the day was upset. On a specified date a similar incident of the same nature occurred. Resident #2 was assessed by an attending physician and was found to have no physical injuries. A review of the resident health care record as well as staff interviews S101(RPN) and S103(Director of Nursing) indicated that the police were not notified of a witnessed incident of abuse.
The Licensee has failed to comply with Ontario Regulation 98 by failing to notify the police immediately of a witnessed incident of abuse that may constitute a criminal offence. [s. 98.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits saillants :

1. On a specified date S101(Registered Practical Nurse) observed Resident #1 touching Resident #2. This touching was of a sexual nature. S101 reported that this was a non consensual act and that resident number #2 appeared frightened. Resident #1 was removed from the area. S101 reported that later in the day resident #2 was crying and upset following this incident. Resident #2 was assessed by an attending physician and assessed as having no physical injury. On a specified date resident #2 health record (progress notes) indicated that a second incident of sexual abuse (same nature) occurred. A critical incident report was submitted to the Ministry of Health and Long Term Care, five days following the first incident of abuse. S101 reported to the inspector on September 16th, 2013 that at a Registered Staff meeting following the incident a discussion occurred that indicated an immediate report should have been made to the Ministry of Health and Long Term Care (MOHLTC) indicating that Resident #2 had been abused. S101 reported that she/he has attended abuse training and was aware of the requirement for immediate reporting of abuse to the Ministry of Health and Long Term Care.
The licensee has failed to comply with Ontario Regulation 107.(2) by not using the MOHLTC after hours emergency contact number and reporting resident abuse. [s. 107. (2)]

Issued on this 19th day of September, 2013

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