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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jan 27, 2016	2016_284545_0001	029789-15	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON N3H 5L8

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

PINECREST NURSING HOME (2797)
101 PARENT STREET P.O. BOX 250 PLANTAGENET ON K0B 1L0

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

ANGELE ALBERT-RITCHIE (545), LINDA HARKINS (126), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 12, 13, 14, 15, 18, 19, 20, 21 and 22, 2016

The following Critical Incidents were inspected as part of the RQI: Log #: O-002792-15,
Log #: O-002806-15 and Log #: 001227-16

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Clinical Nurse, RAI Coordinator, Food Service Supervisor (FSS), Environmental Maintenance Supervisor (EMS), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Workers (PSW), Laundry Attendant, Housekeeping Aide, Physiotherapy Aide, Dietary Aides, Ward Clerk, President of Residents' Council, a Member of Family Council, family members and residents.

The inspector(s) also conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, staff work routines and schedules, observed resident rooms, observed resident common areas, reviewed the admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed a medication pass, observed meal services, and observed the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **2 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rule is complied with: All doors leading

to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The building of the Pinecrest Nursing Home includes only one floor, of which the North and East wing resides the residents of the home. The home's main exit door (west front door) is within the lobby area. The west front door was kept closed and locked, and staff let residents and visitors out by keying an access code on a keypad by the door. Also within the immediate area of the lobby, there was the nursing station, two residents' dining areas, one activity room and 2 to 3 easy chairs, all used by residents. On the wall next to the west front door, a yellow sign was observed indicating that an alarm would be activated if the door was left opened longer than 20 seconds. The west front door was leading into a vestibule, and the door in the vestibule was kept closed and unlocked.

On January 20, 2016 at 0820, Inspector #545 entered the home via the front door. While removing boots in the vestibule, the Inspector observed a family member holding the west front door open as she was talking with the ward clerk. One minute went by and no alarm was activated. After the family member left, the Inspector opened the west front door and kept it opened for over one minute and again, the alarm was not activated.

During an interview with the Administrator/DOC on January 20, 2016, she confirmed that the west front door should have been connected to the home's audio visual enunciator that is connected to the nurses' station near the door and that it should have had a manual reset switch at the door allowing calls to be cancelled only at the point of activation. Later that day, the Administrator/DOC indicated that the technician found two issues with the west front door that were preventing the alarm from being activated when left opened:
• A wire had been severed
• A sensor ("magic eye") was missing from the magnetic lock

On January 21, 2016, the Administrator/DOC indicated that the technician had repaired the wire and installed a magic eye to the magnetic lock, after which time there was an audible door alarm when the door was left opened longer than 20 seconds. Although the audible alarm was now functional, the inspector observed that the alarm turned off as soon as the door was closed.

A door alarm needs to be cancelled by a person at the door to ensure that a resident has not exited the home unsupervised. In a late entry progress note dated January 15, 2016, it was documented that Resident #019 was found in the vestibule, behind the west front door, that the resident had followed an employee who was leaving on a break. The note indicated that the Respiratory Therapist guided the resident back into the home. The Administrator confirmed that Resident #019 was at risk as was frequently observed exit seeking and required close monitoring.

The Administrator/DOC indicated that the technician would be installing a manual reset switch at the door to ensure resident safety. [s. 9. (1) 1. iii.]

2. The licensee has failed to ensure that the door leading to secure outside area off the home's activity room, that preclude exit by a resident, was equipped with a lock to restrict unsupervised access to this area by resident.

On January 12, 2016 Inspector #547 noted during the initial tour of the home for the Resident Quality Inspection, that a door in the unlocked activity room leading to a secured outdoor area was not locked or attended by any staff member at 10:10. An audible door alarm sounded, and the Program Manager arrived with a key at 1016 to turn off the door alarm indicating that it was likely a resident that pushed up against the door knob. The Program Manager indicated that the door was not locked, as the fence gate was kept locked in the secured outdoor area. The Program Manager indicated that the only way to lock this door was from the outside by the Environmental Maintenance Supervisor (EMS). The Program Manager further indicated that the activity room was accessible to residents and families in the home at all times as the doors to this room did not have locks on them and that this room was not always supervised by a staff member.

On January 18, 2016 the EMS indicated that the door in the activity room was locked from the outside, and could not be locked from the inside. The fence gate was kept locked in the secured outdoor area. He was not aware that this door needed to be locked from the inside of the home.

On January 21, 2016 the home's Program manager provided Inspector #547 with the home's policy #OPER-04-02-10 version October 2011 for Secure Outdoor Areas and Balconies that indicated all doors leading to secured outdoor areas and balconies must be equipped with locks and be locked during times specified by the home. This door leading the secured outdoor area had never been locked to residents in the home.

On January 22, 2016 Inspector #547 observed a keyed lock on the door to the secured outdoor area for the residents in the home. The EMS indicated to Inspector #547 that this lock is only opened with a key which was now kept with the Program Manager, the EMS and the Registered Nursing Staff. [s. 9. (1) 1.1.]

Additional Required Actions:

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

WN #2: 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 #031 who is incontinent of bowel received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #031 was admitted to the home in March 2011 with several medical conditions, including diabetes, stroke and a muscle disorder. In a restorative nursing assessment conducted on a specific date in January 2016 it was indicated that the resident was totally dependent for bladder and bowel care, and that the resident was able to communicate his/her needs and understood verbal requests.

During an interview Resident #031 indicated to Inspector #545 that he/she needed to have a bowel movement. The resident indicated to that he/she would like to use the toilet, but was told by the staff to do it in the brief, the resident then added that this was not acceptable. When PSW #104 entered the room, she indicated to the Inspector that the resident was not toileted, and that the resident did it in the brief. Resident #031 then told the PSW and the Inspector that he/she would then have a bowel movement in the tub. Later, PSWs #104 and #101 indicated to the Inspector that Resident #031 was returned to bed to have a bowel movement as it was unsafe to transfer the resident to a commode using a mechanical lift due to the resident's spastic movement. PSW #104 added that the resident often felt like having a bowel movement when was lifted using the bath sling into the tub and that the commode was placed under the resident whenever staff observed the resident having a bowel movement, when getting ready for a tub bath.

In a review of the most recent plan of care it was indicated that Resident #031 needed assistance with toileting due to lack of voluntary muscle control. Toileting was described as a transfer back to bed for change of brief, and that the resident was incontinent of bowel and bladder. Under the section: Constipation, it was documented that due to decreased mobility secondary to a stroke and daily narcotic use, the resident was at risk for constipation. It was also documented that the resident was transferred via a mechanical lift.

A review of the PSW Flow Sheet for the month of January 2016, it was indicated that the resident had a bowel movement every 3 to 5 days.

RPN #103 indicated to the Inspector that Resident #031 often knew when he/she had an urge to have a bowel movement, but that staff did not toilet the resident due to involuntary movements, then added that the Resident wore a brief and had his/her bowel movement in it.

The RAI Coordinator indicated that upon admission, she conducted a Bowel Assessment using an assessment instrument that was specifically designed for assessment of incontinence, and again when she observed a decrease or increase of incontinence pattern when reviewing the PSW Flow Sheet on a quarterly basis. She further indicated that no bowel assessment had been conducted for this resident. [s. 51. (2) (a)]

2. The licensee has failed to ensure that Resident #028 who is incontinent of bladder received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is

conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #028 was admitted to the home in April 2015 with several medical conditions including diabetes, heart and pulmonary conditions and depression. According to the most recent assessment, the resident was frequently incontinent of bladder, and using a continent product.

During observations on January 14 and 21, 2016 Inspector #545 observed a lingering odor near Resident #028. Two urinals were observed; one hanging on the garbage at the foot of the resident's bed, and a second one on the mini-fridge by the bed; both urinals were empty.

The Resident indicated to the Inspector that he/she wore a brief and had difficulty pulling down his/her pants & brief to use the urinal and consequently had frequent accidents. The resident then indicated that he/she required assistance to transfer onto the toilet, and did request for help when wanted to use the toilet.

Upon review of Resident #028's health record, it was documented in a Bladder Continent Assessment dated a specific date in April 2015 that the resident was continent of bladder on day, evening and night shifts, that the resident was taking daily diuretic, antidepressant, anti-hypertensive, and required assistance for toileting due to limited mobility. The assessment also indicated that the resident was aware of urge to void, and was motivated to be continent. In the most current plan of care it was indicated that Resident #028 required extensive assistance of one person for toilet use, that he/she wore a large pad on days and evenings and a brief at night. The staff was directed to set a toileting schedule with the resident and respond promptly upon request for assistance to the bathroom.

During an interview with PSW #111 she indicated that the Resident wore a brief at all times for frequent bladder incontinence episodes. She indicated that Resident #028 did have accidents when trying to use the urinal by self. She indicated that she offered the resident to use the toilet regularly, added that the previous day she had offered Resident #028 assistance prior to the end of the day shift and the resident had declined, stating that someone else had already provided assistance, however when she checked with her colleagues, found out no one had provided assistance.

The RAI Coordinator indicated that she was responsible in conducting Continence Assessments, upon admission and with any deterioration in continence level. She indicated that one was completed upon admission, however in June 2015 when the resident became frequently incontinent of bladder, no continence assessment was completed to identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions. The RAI Coordinator indicated that approximately one month ago the resident was changed from a pull-up to a brief due to increased bladder incontinence. She was unable to find documentation regarding this bladder continence deterioration.

In an interview with the Administrator/DOC, she indicated to Inspector #545 that it was the home's expectation that registered staff complete a bowel and bladder continence assessments using the home's OE Bladder Continence Assessment & the OE Bowel Continence Assessment, upon admission and again with any deterioration in continence level. [s. 51. (2) (a)]

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 Resident #031 and Resident #028 receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug, such as daily application of a pain relief topical ointment is used by or administered to Resident #040 unless the drug has been prescribed for the resident.

According to an assessment dated a specific date in September 2015, Resident #040 experienced daily moderate pain to a specific area due an acute episode or a flare-up of a recurrent or chronic problem and was taking daily analgesics.

On January 19, 2016, the Inspector observed a jar of pain relief topical ointment with Resident #040's name on it, in the resident's shared bathroom.

On January 19, 2016, PSW #104 indicated that she applied a pain relief topical ointment to a specific area on Resident #040's body every morning during care provision as the resident complained of pain. She further indicated that the pain relief topical ointment should be kept in the Treatment Cart.

During an interview with RPN #103 she indicated that a pain relief topical ointment was considered a medication, and that it was the home's practice to get a physician's order for application of a pain relief topical ointment and that it should be kept in the Treatment Cart. After checking the resident's health record, the RPN indicated that there was no order, and that she was not aware that staff applied a pain relief topical ointment to this resident.

The Administrator/DOC indicated that it was the home's practice to get a physician's prescription for a pain relief topical ointment application and for PSW to document application of treatment in the Treatment Administration Record. [s. 131. (1)]

2. The licensee has failed to ensure that drugs are administered to Resident #012 in accordance with the directions for use specified by the prescriber.

Log #: O-002792-15
Resident #012 was diagnosed with several medical conditions, including heart & pulmonary conditions, diabetes, mental illness with a moderate cognitive impairment.

Upon review of the resident's medication administration record (MAR) for the month of September 2015, it was documented that Resident #012 was prescribed an anti-epileptic medication four times daily at 0700, 1200, 1600 and 2000 as a mood stabilizer related.

In a review of a letter dated a specific date in September 2015 addressed to the Administrator/DOC, written by RPN #114, it was documented that when she observed a missing dose (evening dose) of the anti-epileptic medication from the medication bin for Resident #012 on a specific date in September 2015. The RPN asked RN #115 who was on duty that evening, of location of the anti-epileptic medication for the 2000 dose. The RN responded that she always administered the 1600 and 2000 doses at once around 1530, as the resident insisted on receiving both doses at the same time.

During an interview with the Administrator/DOC she indicated that she approached RN #115 on same day she was informed by RPN #114 of the medication error. The Administrator/DOC indicated that the RN told her she always administered a double dose of the anti-epileptic medication (supper & evening dose at once) to Resident #012 before supper as the resident insisted. The Administrator/DOC further indicated to Inspector #545 that the Resident was observed on that day to be excessively drowsy and unable to eat supper or take fluids, and added that the resident was at increased risk for falls due to receipt of a double dose of the anti-epileptic medication. The Administrator/DOC indicated that she terminated employment for RN #115 that day, and reported the incident to the College of Nurses. [s. 131. (2)]

3. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On January 13, 15 and 18, 2016, Inspector #126 observed a tube of nonsteroidal anti-inflammatory topical gel and a jar of pain relief topical ointment on the bedside table of Resident #014.

Resident #014 indicated that he/she used the gel & ointment for discomfort of a limb. The resident indicated that the nonsteroidal anti-inflammatory topical gel was purchased by self from the Pharmacy in the community and that the pain relief topical ointment was provided by the nursing staff.

Inspector #126 reviewed the Medication Administration Record (MAR) and there was no order for self-administration for the nonsteroidal anti-inflammatory topical gel and the pain relief topical ointment.

Discussion held with the Administrator/DOC on January 19, 2016 indicated that the home did have a policy on self-administration but that she was not aware of any resident administering medication to himself or to herself. [s. 131. (5)]

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 administers a pain relief topical ointment to Resident #040, only if it has been prescribed, ensure that Resident #012 is administered drugs in accordance with the directions for use specified by the prescriber, and ensure that Resident #014 is allowed to self-administer a non-steroidal anti-inflammatory topical gel and a pain relief topical ointment only if approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for Resident #040 that sets out, the planned care, goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident related to use of a personal alarm.

Inspector #545 observed Resident #040 sitting in a wheelchair with a personal alarm clipped to his/her shirt or sweater and attached to the back of the wheelchair, from January 13 to 20, 2016.

Upon review of the resident's health record, it was indicated that the Resident was at high risk for falls, and that the resident had six falls between August and December 2015. The resident's plan of care was reviewed, and information regarding the use of a personal alarm was not found.

During an interview with PSW #104 she indicated that the resident was at risk for falls, that she was not aware of the resident trying to get out of the wheelchair or bed as he/she feared falling. She indicated that a personal alarm was used as a safety device to alert staff in case the resident tried to get out of the wheelchair.

PSW #109 indicated that Resident #040 was at risk for falls and upon return from the Emergency Department on a specific date in October 2015, he remembered that a personal alarm was applied as a safety device as the resident was making attempts of getting out of the wheelchair and falling.

The Clinical Nurse indicated that it was the home's practice to document planned care for the use of a personal alarm applied as a safety device, in the resident's care plan. She also indicated that in the PSW Daily Flow Sheets, an indication of the use of a personal

alarm should be provided to ensure that staff verified the batteries once per shift. After reviewing the plan of care, the Clinical Nurse indicated that there was no planned care for Resident #040 related to use of a personal alarm, no goals the care was intended to achieve; and no clear directions to staff and others who were providing direct care to Resident #040. [s. 6. (1)]

2. The licensee failed to ensure that there is a written plan of care for each resident that sets out, the planned dental care for the resident.

Resident #040 indicated to the Inspector during an interview, that he/she had difficulty chewing because the dental prosthetic devices he/she owned were old. The resident indicated that staff cleaned them, as he/she was unable to do by self.

Upon review of the resident's plan of care, planned dental care for this resident was not found. According to the most recent assessment, it was indicated that the resident required extensive assistance of two staff for personal hygiene, including dental care.

During an interview with PSWs #107 and #108, they indicated that the Resident had two prosthetic devices and required assistance for dental care. PSW #107 indicated that the prosthetic devices were brushed with a regular toothbrush and toothpaste, and at night they were soaked in water with a cleaning tablet.

RN #106 indicated that it was the expectation of the home that dental care be included as part of the care plan, especially for residents like this one who required extensive assistance. After reviewing the plan of care she indicated that the dental care information was missing. [s. 6. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that Residents #024, #031 and #039's shared

bedrooms occupied by more than one resident had sufficient privacy curtains to provide privacy.

Resident #024's privacy curtains were noted to not provide the resident privacy he/she requested, as the curtains bounced back when pulled to full extent around the resident's bed. Resident #024 indicated to Inspector #547 on January 20, 2016 that he/she preferred to tie the curtains closed, as liked own privacy, and did not want anyone to see him/her when sleeping. The resident further indicated that he/she had to wrap the curtain located between both residents in this shared room, around own mattress to keep it tight, as the other resident moved it when he/she walked around Resident #024's bed. Resident #024 also placed a garbage can at the other end of the curtain, to keep the curtain closed to the main North resident hallway.

PSW #104 indicated to Inspector #547 on January 20, 2016 that the resident had always done this with the curtains, as the resident wanted privacy and the curtains did not close completely, and Resident #024 preferred to sleep with no clothes on, only wearing a pull-up style brief, and did not want anyone to see him/her.

Resident #024 further indicated to Inspector #547 that he/she would prefer a private room, as the curtains did not provide enough privacy. The resident did not like the fact the mesh was so large at the top of the curtain and people could peek over to see him/her. Inspector #547 noted that the resident's privacy curtains did have a large see-through mesh and standing on the outside of the curtain, Inspector #547 could see Resident #024 laying in bed. [s. 13.]

2. On January 13, 2016 Inspector #545 observed Resident #031's privacy curtain not long enough to provide this resident complete privacy as it had a two foot gap in the privacy curtain facing the North resident hallway.

On January 20, 2016 Inspector #547 brought the Environmental Maintenance Supervisor (EMS) to the residents' room to view the privacy curtains. The EMS indicated that many of the curtains were being changed or had already been changed. He indicated that he was not aware that these curtains were not able to close completely and would have to figure out a way to fasten them to the walls somehow to ensure privacy for these residents. [s. 13.]

3. On January 14, 2016 Inspector #545 noted that Resident #039's privacy curtains could not provide privacy as the privacy curtain was missing an entire panel along the

resident's bed facing the doorway to the North resident hallway. The North resident hallway was utilized frequently by Residents #019, #031, and #035 who wandered the hallway regularly on days and evenings.

On January 20, 2016 Inspector #547 brought the Environmental Maintenance Supervisor (EMS) to the resident's room to view the privacy curtains for this resident, and noted that the curtain hooks were not rolling properly in the track, and this was actually damaging the curtain as staff had tried to pull the curtain closed, to provide this resident privacy and the hooks were stuck in the rails. This privacy curtain issue for Resident #039 was not brought to his attention until now. This resident's privacy curtain had a gap of 5 feet facing the doorway that prevented the resident from having privacy from those walking in the North resident hallway. [s. 13.]

WN #6: 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. The licensee has failed to ensure that an incident of abuse of a resident by staff that resulted in harm was not immediately reported to the Director.

In accordance with O.Reg 79/10, for the purposes of the definition of "abuse" in

subsection 2 (1) of the Act:

• “emotional abuse” means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences;
(“mauvais traitement d’ordre affectif”)

• “physical abuse” means, subject to subsection (2),
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident;
(“mauvais traitement d’ordre physique”)

For the purposes of clause (a) of the definition of “physical abuse” in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

Log #: O-002806-15
Resident #042 had several medical conditions, including anxiety and dementia, with known responsive behaviours of resistance to care, verbal and physical aggression. According to the most recent plan of care, interventions included redirecting the resident using a gentle persuasion approach, and for staff to contact the resident’s family member if the resident became agitated.

Upon review of the home’s investigation notes, it was documented that on a specific date in September 2015, an incident of physical abuse between Nursing Staff #114 and Resident #042 occurred in the front hallway that resulted in harm. Resident #042 was observed ambulating in the hallway carrying another resident's sweater. Staff observed Nursing Staff #114 arguing with the resident and pulling the sweater away from Resident #042. Nursing Staff #114 then directed another staff to bring the sweater to the laundry and to return it to the rightful owner. Resident #042, who believed the sweater was his/hers, became agitated and physically aggressive toward Nursing Staff #114

demanding to have his/her sweater. Nursing Staff #114 refused and showed the resident that the sweater was not his/hers. The notes also indicated that four Personal Support Workers (PSWs) reported observing Nursing Staff #114 protecting herself by grabbing both wrists of Resident #042 with excessive force to contain both arms at the back of the resident. Resident #042 was pleading with Nursing Staff #114 to let him/her go because Nursing Staff #114 was hurting him/her. The PSWs also reported that Nursing Staff #114 backed Resident #042 into a chair, holding both wrists of the resident, then sat the resident into the chair.

Resident #042 did not sustain any injury. The investigation was initiated by the Administrator/DOC and the following day Nursing Staff #114 was suspended with pay then terminated 11 days later.

The incident was not immediately reported to the Director; it was reported two days after the incident, on September 23, 2015 via the Critical Incident System. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #039 receive individualized personal care, including hygiene care and grooming such as shaving, on a daily basis.

Resident #039 was admitted to the home in October 2015 with dementia. According to the most recent assessment, the resident required extensive assistance of two persons for personal hygiene, which includes shaving. The resident was also assessed as exhibiting verbal and physical aggression and was resistive to care.

On January 14 and 20, 2016 the Inspector observed Resident #039 unshaved.

A review of Resident #039's plan of care was done by Inspector #545. Under Personal Hygiene, it was documented to provide assistance by setting up the razor for this

resident to shave.

Upon review of the Daily Flow Sheet for the month of January 2016, it was documented that Resident #039 was shaved 6 out of 20 times. In a written note by a PSW dated a specific date in January 2016, it was indicated that Resident #039 was aggressive and had refused care in the evening. There was no indication of refusing shaving by staff.

A progress note written by a registered staff dated earlier in the month of January 2016 indicated that the resident had refused care. No other notes were found for the month of January 2016.

During an interview with PSW #104, she indicated that Resident #039 required guidance and setup for shaving, but today she had not shaved the resident as he/she was verbally aggressive during care and she feared being hit by the resident. The PSW indicated that she should have returned to offer at a later time but did not.

RPN #103 indicated that she had not been notified today by the PSW when Resident #039 refused to be shaved. She indicated that it was her responsibility to document refusal of care, when she was informed by PSW, then she could ensure staff returned later to offer care. The RPN further added that it was the expectation of the home that residents be shaved daily.

During an interview with the Administrator/DOC, she indicated that staff were expected to provide personal hygiene including shaving to Resident #039 on a daily basis, and to document care provision and/or refusal and to notify registered staff when the Resident refused. [s. 32.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #031 receive fingernail care, including the cutting of fingernails.

Resident #031 was observed by Inspector #545 on January 13 and 18, 2016 with dark brown debris and dirt under the nails of the right hand and some lighter debris in two fingernails of the left hand. The Inspector observed the resident eating his/her meal with the right hand on both these days.

According to the most recent assessment, Resident #031 required total assistance of staff for personal hygiene including nail care. It was also documented that the resident required extensive assistance of one person with eating, with limitation and partial loss of one limb.

In the most recent plan of care, it was indicated that due to lack of voluntary muscle control, Resident #031 required assistance of registered staff to cut nails due to diabetes. The Flow Sheet was reviewed, and it was indicated that nails were trimmed twice weekly in the month of January when was provided a tub bath.

During an interview with PSW #101, she indicated that nail care was provided during bath and any time when the resident's nails were unclean, added that her partner had provided morning care on January 18, 2016.

PSW #100 indicated that she had provided care to the resident earlier on January 18, 2016, then added that she had not provided nail care to the Resident.

RPN #103 observed Resident #031's nails and indicated that the nails were unclean and a little too long, and that she would ensure that staff provided nail care.

The Clinical Nurse indicated to the Inspector that Resident #031 ate with his/her hands and often got food stuck in the fingernails, therefore required nailcare by staff after each meal. [s. 35. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee sought out the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

On January 19, 2016 Inspector #547 interviewed a member of the Family Council who indicated that the Council was not asked how to develop and carry out the satisfaction survey. She could recall completing one in the Fall.

On January 19, 2016 the Program Manager who was assigned as Family Council assistant, indicated that the survey was received in September 2015 and was reviewed at the Family Council meeting held in October 2015.

The Administrator/DOC indicated that the satisfaction survey was received from Extendicare head office, and was printed and sent to all families in September 2015 to be completed and returned to the home.

The Family Council assistant indicated that the satisfaction survey was already mailed to families by the time she discussed this with members of the Family Council in October 2015 which was too late to change any questions for the 2015 survey. The Family Council assistant further indicated that it was also too late to ask the members how the Satisfaction survey should have been carried out in the home, as the residents completed their satisfaction surveys in September 2015 after it arrived in the home from Extendicare head office. [s. 85. (3)]

WN #10: 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. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse.

Log #: O-002806-15
As per WN #6: Reporting Certain Matters to the Director, an incident of physical abuse between Nursing Staff #114 and Resident #042 occurred in the front hallway that resulted in harm, on a specific date in September 2015.

The following day, Nursing Staff #114 was suspended and six days later, she received termination of employment.

On January 22, 2016, Inspector #126 interviewed the Administrator/DOC who indicated that the Police was not notified of the incident as of this date. [s. 98.]

Issued on this 28th day of January, 2016

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

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

Ministére 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ANGELE ALBERT-RITCHIE (545), LINDA HARKINS (126), LISA KLUKE (547)
Inspection No. / No de l'inspection :	2016_284545_0001
Log No. / Registre no:	029789-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 27, 2016
Licensee / Titulaire de permis :	CVH (No.4) GP Inc. as general partner of CVH (No.4) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes Inc., CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	PINECREST NURSING HOME (2797) 101 PARENT STREET, P.O. BOX 250, PLANTAGENET, ON, K0B-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Diane Pelletier

To CVH (No.4) GP Inc. as general partner of CVH (No.4) LP, 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 :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee will ensure that the west front door that leads to the outside of the home:
1. Is equipped with an audible door alarm that allows calls to be cancelled only at the point of activation;

2. Has a manual reset switch at the west front door; and

3. Is monitored to ensure resident safety until such time when compliance with items 1 and 2 above is achieved in accordance with section 9 of O. Reg. 79/10.

Grounds / Motifs :

1. The licensee failed to ensure that the following rule is complied with: All doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The building of the Pinecrest Nursing Home includes only one floor, of which the North and East wing resides the residents of the home. The home's main exit door (west front door) is within the lobby area. The west front door was kept closed and locked, and staff let residents and visitors out by keying an access code on a keypad by the door. Also within the immediate area of the lobby, there was the nursing station, two residents' dining areas, one activity room and 2 to 3 easy chairs, all used by residents. On the wall next to the west front door, a yellow sign was observed indicating that an alarm would be activated if the door was left opened longer than 20 seconds. The west front door was leading into a vestibule, and the door in the vestibule was kept closed and unlocked.

On January 20, 2016 at 0820, Inspector #545 entered the home via the front door. While removing boots in the vestibule, the Inspector observed a family member holding the west front door open as she was talking with the ward clerk. One minute went by and no alarm was activated. After the family member left, the Inspector opened the west front door and kept it opened for over one minute and again, the alarm was not activated.

During an interview with the Administrator/DOC on January 20, 2016, she confirmed that the west front door should have been connected to the home's

audio visual enunciator that is connected to the nurses' station near the door and that it should have had a manual reset switch at the door allowing calls to be cancelled only at the point of activation. Later that day, the Administrator/DOC indicated that the technician found two issues with the west front door that were preventing the alarm from being activated when left opened:
• A wire had been severed
• A sensor ("magic eye") was missing from the magnetic lock

On January 21, 2016, the Administrator/DOC indicated that the technician had repaired the wire and installed a magic eye to the magnetic lock, after which time there was an audible door alarm when the door was left opened longer than 20 seconds. Although the audible alarm was now functional, the inspector observed that the alarm turned off as soon as the door was closed.

A door alarm needs to be cancelled by a person at the door to ensure that a resident has not exited the home unsupervised. In a late entry progress note dated January 15, 2016, it was documented that Resident #019 was found in the vestibule, behind the west front door at 1630, that the resident had followed an employee who was leaving on a break. The note indicated that the Respiratory Therapist guided the resident back into the home. The Administrator confirmed that Resident #019 was at risk as was frequently observed exit seeking and required close monitoring.

The Administrator/DOC indicated that the technician would be installing a manual reset switch at the door to ensure resident safety. (545)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2016

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Angele Albert-Ritchie

Service Area Office /
Bureau régional de services : Ottawa Service Area Office