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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 15, 2016	2016_284545_0017	O-026399-15/015779-16	Critical Incident System

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)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 16 and June 21, 2016

The Critical Incident Inspections for Log #: O-026399-15 and Log #: 015779-16 are related to two critical incidents the home submitted related to allegations of physical abuse to residents by other residents.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Clinical Nurse, RAI Coordinator, Registered Practical Nurses (RPN), Behavioural Support Ontario (BSO) PSW, Personal Care Workers (PSW), family members and residents.

The Inspector also conducted a tour of the resident care areas, reviewed residents' health care records, home's zero tolerance of abuse policy, observed residents' rooms, observed residents' common areas, and observed the delivery of resident care and services, including resident-staff interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care, such as monitoring

every 15 minutes, as set out in the plan of care for resident #017, was documented.

On a specified date in May 2016, resident #017 pushed resident #016 and was observed kicking the resident while the resident laid on the floor in front of resident #017's bedroom. Resident #016 sustained a hip fracture, was sent to hospital and had surgery, and returned to the home seven days later.

In a review of resident #017's written plan of care dated on a specified date in May 2016 staff were directed to provide the resident with privacy and a quiet setting by keeping the resident's bedroom door closed. It was also documented that an alarm type device was installed on the resident's bedroom door.

In a progress dated on a specified date in June 2016, the Geriatric Services registered nurse, indicated that due to approximately 10 residents that wandered in the home, it would be strongly recommended that close monitoring every 15 minutes of resident #017 be started and continued until reassessed by the psycho-geriatrician two weeks later. A note indicated that if there was a cancellation on a specified date in June 2016, the psycho-geriatrician might be able to come earlier.

According to resident's revised plan of care updated on the date the Geriatric Services RN visited, it was documented that close monitoring every 15 minutes was started for all shifts to ensure that wandering residents did not enter resident #017's bedroom.

Upon review of the Behaviour Monitoring flow sheet, it was indicated: Verify resident #017 every 15 minutes to prevent aggressive behaviours. Documentation of "every 15 minutes verification" was reviewed and it was noted that monitoring was not documented on the following dates and times:
- on a specified date in June 2016 (5:15-5:45)
- on a specified date in June 2016 (00:30 to 2:45)
- on four specified dates in June 2016 (night shift)
- on two specified dates in June 2016 (evening shift)

During an interview with the BSO PSW, he indicated that the psychogeriatrician would be reassessing the resident on a specified date in June 2016. He indicated that monitoring was required every 15 minutes until the resident was reassessed by the psychogeriatrician. In reviewing the Behavioural Monitoring flow sheet, he confirmed that there was several periods where the monitoring was not documented; he later indicated that the flow sheet had been filed away on the weekend and staff did not complete the

documentation. [015779-16] [s. 6. (9) 1.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with the home's written policy that promotes zero tolerance of abuse and neglect of residents.

The home's current abuse policy titled: Extendicare Zero Tolerance: Resident Abuse, Resident Rights and Commitment to Residents Tab 2, RC-02-01-01, revised April 2016 was reviewed by the Inspector. It was documented under section Reporting, that:

1. Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/ designate/ reporting manager or if unavailable, to the most senior Supervisor on shift at that time. Note: In Ontario, in addition to the above, anyone who suspects or witnesses abuse, incompetent care or treatment of a resident, misappropriation of funds (resident or funds provided to the licensee under the LTCHA or the Local Health Systems Integration Act, and/or neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long Term Care (Director) through (Whistleblower protection) from retaliation. Appendix 1 and Appendix 7, Reference Mandatory and Critical Incident Report Policy – province specific.

2. The person reporting the suspected abuse will follow the home's reporting/ provincial requirements to ensure the information is provided to the home Administrator/designate immediately.

Inspector #545 reviewed the Critical Incident Report (CIR) submitted to the Director

under the LTCHA on a specified date in September 2015 for an alleged physical abuse of a resident by another resident that occurred two days earlier, in September 2015. It was noted that resident #002's family member reported to the Clinical Nurse at 1000 hours on a specified date in September 2015 that another resident entered resident #002's room one evening and slapped the resident on the face; redness was observed on the left side of the resident's neck. According to the note, resident #002 was able to identify the aggressor.

A review of resident #002's health record was conducted by the Inspector. In a progress note dated on a specified date in September 2015 it was documented that resident #002 had reported that resident #003 was in his/her room and slapped him/her in the face. RPN #112 documented that the resident was offered support and told that something would be done to reduce the risk.

During an interview with the Administrator/DOC she indicated that she was present in the home on the day the incident occurred, however RPN #112 who had reasonable grounds to suspect that a physical abuse of resident #002 by resident #003 that resulted in harm or risk of harm, did not notify her. Note that RPN #112 was no longer an employee of the home at the time of the inspection.

The Clinical Nurse, indicated to the Inspector that she was absent on the day the incident occurred and was made aware of the physical abuse to resident #002 by resident #003 the following day, upon return to the home. She added that she was unable to explain why she did not immediately report the physical abuse on when she became aware, as per the home's Zero Tolerance of Abuse policy. (O-026399-15) [s. 20. (1)]

WN #3: 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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #016's Substitute Decision Maker (SDM) was notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

The Critical Incident Report (CIR) submitted by the home on a specified date in May 2016 for an alleged physical abuse to resident #016 by resident #017 that occurred on a specified date in May 2016 was reviewed by Inspector #545. According to the CIR, resident #016 was found on the ground in front of resident #017's bedroom door while this one was kicking resident #016's feet. Resident #016 was sent to hospital, and was diagnosed with a hip fracture.

In a progress note dated seven days post incident, it was documented that resident #016's SDM was informed of resident transfer from hospital back to the home. Information related to communication of investigation to the SDM was not found.

When asked if the results of the alleged physical abuse investigation was communicated to resident #016's SDM immediately upon completion, the Clinical Nurse responded that she was not aware that this was a requirement, therefore had not notified the SDM.

On June 21, 2016, the Administrator/DOC indicated to the Inspector that she had conversations with resident #016's SDM some time after the incident occurred but could not validate as documentation was not available. She further indicated that Extendicare had provided investigation training last week, and that going forward documentation of investigations would be done as per legislation. [015779-16] [s. 97. (2)]

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

Issued on this 19th day of July, 2016

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

Original report signed by the inspector.