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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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
Feb 27, 2017	2016_535557_0016	032870-16	Critical Incident System

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 KELLY DRIVE GRAVENHURST ON P1P 1P3

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

VALERIE PIMENTEL (557)

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): November 24, 25 and December 15, 2016.

The following Critical Incidents (CI) was inspected: Intake Log #032723-16 related to a fall with injury.
The following complaint was inspected concurrently: Intake Log #034365-16 related to the above CI

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Assistant Director of Care (ADOC), Environmental Service Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Police Constable, Residents and Substitute Decision Makers (SDM).

The inspector observed staff and resident interactions, observations of the home areas, record review of resident and home records, and reviewed relevant policy and procedures related to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 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.O. 2007, c.8, 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 :

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

In an identified month in 2016, the home initiated a critical incident report (CI), in respect to an identified resident. The home contacted the Ministry of Health and Long Term Care after hour pager. The CI identified a resident was found by an identified staff member with the resident in a compromised position half in and half out of bed. The resident was bleeding from an identified body part. There was only one appliance engaged on the bed when there should have been two appliances engaged. The resident was monitored and reassessed, the next shift, a decision was made to send the resident to the hospital for further assessment. The resident returned the same day with a diagnosis of a an identified injury to an identified body part.

Record review of the health care record for the resident revealed the following:
- A Cognitive performance scale (CPS) had been completed which indicated a cognitive impairment.
-The written plan of care, kardex, point of care (POC) and physician orders identified the resident is to have two appliances engaged when in bed and to have safety checks every hour when the appliances are engaged.

-POC documentation on an identified A shift revealed the following:
-two consecutive identified hours revealed the appliances were not engaged.
-the following three consecutive identified hours revealed the appliances were engaged, the inspector noted that the above documentation entries were made at an identified time.
-the last entry for an identified hour revealed the appliances were engaged. The inspector observed this entry was made ten minutes before the actual observation and time by an identified staff member.

Review of the documentation with the A shift, the identified staff member confirmed he/she had documented in POC as noted above and confirmed the documentation was not accurate.The staff member further stated he/she did not actually enter the room and may have glanced into the room as they passed by and further indicated that they were busy and were working short staffed.

-POC documentation by the identified B shift revealed the following:
-at a specified hour revealed the appliances were not engaged, the safety check had been completed and the resident's response was unsettled and uneasy.
- the following hour revealed the appliances were engaged, the safety check was completed and the resident's response remained unsettled and uneasy. The inspector noted that the above documentation entries were made at an identified time frame after

the incident.

An identified staff member from the B shift told the inspector that he/she heard a resident making a noise from an identified room. This staff member further indicated that he/she found the resident in a compromised position. The resident was bleeding from identified body parts. The staff member confirmed that the one appliance had not been engaged when he/she found the resident in a compromised position on the floor. The staff member added that the resident had fallen out of the side of the bed where there were no appliances engaged.

Progress notes from the B shift revealed when the resident was found he/she had one appliance engaged. The resident was identified to have identified injuries. The exact time of the incident was not identified. The call bell alarm history report identified the the pager system was activated from resident bathroom at an identified time. An identified staff member informed the inspector he/she had activated the emergency call bell to call for assistance when he/she found the resident in a compromised position.

Interview with an identified registered staff member from the A shift confirmed he/she observed the resident's appliance engaged when he/she went into the room at an identified time to administer medication to the identified resident's roommate. The staff member further stated that he/she documented in POC confirming the use of the two appliances.

Interviews with three identified staff members confirmed the resident was supposed to have two appliances engaged when in bed.

The identified resident was not able to be interviewed due to cognitive impairment.

Review of the home's investigation notes revealed that the home had suspended an identified staff member pending investigation because the appliances were not engaged as specified in the plan of care.

Interview with the ADOC confirmed the home did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan to have two appliances engaged when the resident was in bed.

The severity of harm was actual harm to the identified resident, the licensee failed to engage the resident's appliances and the resident sustained multiple injuries as a result.

A review of the compliance history identified non-compliance with a voluntary plan of correction unrelated to falls. The scope of this non-compliance was isolated. [s. 6. (7)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

The home's policy LTC Resident Care, titled "Restraint Implementation Protocols", Policy #VII-E-10.00, dated November 2015, identified the following: the registered staff are to review and document every eight hours on the restraint monitoring record the need for continued restraint and to evaluate quarterly and at any time as required.

Record review of the registered staff evaluation of the assessments for continued restraint use for an identified month in 2016, revealed on 15 identified calendar days there was missed documentation on day, evening and or night shift.

Record review of the resident's Restraint/PASD Assessment record revealed only one assessment was completed on an identified day in 2016.

Interviews with an identified registered staff member and the ADOC confirmed that the documentation was incomplete on identified dates and shifts by different registered staff and confirmed there was only one evaluation that could be found as being completed.

An interview with the ADOC confirmed the home did not follow their policy in regards to restraint implementation protocols and it is the home's expectation that all registered staff assess the need for the use of a restraint every eight hours and that the assessment is documented and to ensure quarterly assessments are completed. [s. 8. (1) (b)]

Issued on this 28th day of February, 2017

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2016_535557_0016
Log No. / Registre no:	032870-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 27, 2017
Licensee / Titulaire de permis :	2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP 302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Muskoka Shores Care Community 200 KELLY DRIVE, GRAVENHURST, ON, P1P-1P3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Coutts

To 2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 shall prepare, implement and submit a plan of corrective action which includes but is not limited to the following elements:

1) How the home will ensure that the care set out int he plan of care is provided to the resident as specified in the plan of care.

2) Identify a process to ensure that risk factors are identified, implemented and reviewed for residents at risk of falling out of bed.

3) Outline how the licensee will ensure staff adherence to the compliance plan.

For all elements of the compliance plan, please identify times lines and the name of the person(s) responsible for completing the tasks and the time lines for completion. The plan shall be submitted on or before March 31, 2017, to valerie.pimentel@ontario.ca

Grounds / Motifs :

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

In an identified month in 2016, the home initiated a critical incident report (CI), in respect to an identified resident. The home contacted the Ministry of Health and Long Term Care after hour pager. The CI identified a resident was found by an identified staff member with the resident in a compromised position half in and half out of bed. The resident was bleeding from an identified body part. There was only one appliance engaged on the bed when there should have been two appliances engaged. The resident was monitored and reassessed, the next shift,

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The severity of harm was actual harm to the identified resident, the licensee failed to engage the resident's appliances and the resident sustained multiple injuries as a result. A review of the compliance history identified non-compliance with a voluntary plan of correction unrelated to falls. The scope of this non-compliance was isolated. [s. 6. (7)] (557)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

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
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 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
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 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Pimentel

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