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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 9, 2018	2018_669642_0019	001806-17, 003203-17, 004729-17, 004942-17, 005190-17, 006116-17, 008119-17, 008900-17, 011519-17, 013631-17, 014611-17, 020930-17, 024504-17, 028070-17, 001077-18, 002587-18, 003958-18, 004254-18, 004783-18, 006065-18, 006604-18, 007627-18, 008057-18, 008919-18, 009570-18, 014879-18, 014890-18, 015010-18	Critical Incident System

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 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

AMY GEAUVREAU (642), JENNIFER BROWN (647), SHELLEY MURPHY (684)

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): July 16-20, 23-27, 2018.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:

Six CIS intakes: related to alleged staff to resident abuse or neglect.

Thirteen CIS intakes: related to alleged resident to resident abuse.

Six CIS intakes: related to falls.

One CIS intake: related to a missing resident.

Two CIS intakes: related to disease outbreaks.

A Follow Up inspection #2018_669642_0021 and a Complaint inspection #2018_669642_0020 were conducted concurrently with this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Managers/ Assistant Director of Care (ADOC), Registered Social Service Worker, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assessment Instrument (RAI) Coordinator RPN, Personal Support Workers (PSWs), Behavioural Support Ontario (BSO) RN, BSO RPNs, BSO PSW, residents and family members.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes, staff education records, as well as reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 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 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

The home submitted a Critical Incident (CI) report to the Director, indicating that resident #004 was found on the floor, with no mobility safety device functioning. Resident #004 was transferred to the hospital for further assessment where they were diagnosed with an injury.

Inspector #647 had reviewed resident #004's clinical records which included the progress notes and the plan of care. The records indicated the resident had been identified as a high risk for falls due to behaviours. The resident had an intervention put in place on a day in September 2017, to ensure the safety device was applied to resident #004 when they were up in their mobility device. The progress notes indicated that when the resident had been found on the floor, the mobility safety device was not functioning.

The Inspector interviewed PSW #126, who indicated that they had been working at the time of the incident, when resident #004 required the mobility safety device due to their high risk of falls. PSW #126 further indicated that when the resident was observed after the fall, the safety device was not functioning.

Inspector #647 observed resident #004 on a day in July, 2018, with a certain mobility safety device and a second safety device in place. Upon closer observation, Inspector #647 observed resident #004's mobility safety device was not functioning. PSW #127 confirmed at the time of this observation that the mobility safety device was not

functioning to ensure resident safety and as directed by the resident’s plan of care.

During an interview with the Director of Care (DOC), they indicated that the plan of care for resident #004, had not been followed as the mobility safety device had not been functioning and the plan of care continued to not be followed, as evidenced by the Inspectors observation on a day in July, 2018. [s. 6. (7)]

2. The home had submitted a CI report to the Director, which alleged staff to resident abuse. PSW #134 was observed and was reported as being rough with resident #011, and had moved the resident faster than necessary, to the point the resident was complaining of pain after the incident.

Inspector #684 reviewed the home's investigation notes which indicated that PSW #134, admitted they had not read resident #011's care plan/kardex as required, to ensure they were providing the correct care to resident #011.

The Inspector reviewed the care plan for resident #011, which stated the following: I use a mobility device. I can move myself, but I like when people help me with my mobility device, as well. I also use another mobility device within my room with a team member's assistance x 1.

During an interview with PSW #134, they had told Inspector #684 that they usually looked at the kardex at the start of their shift to know what care the residents required. PSW #134 indicated that they had provided care to resident #011 and were unaware that the resident’s care status had changed and the resident now required a different mobility device for mobility. Inspector #684 asked PSW #134 if they had checked resident #011’s plan of care at the start of the shift, the day of the incident, and the PSW indicated, "no" they had not.

Inspector #684 reviewed the policy titled, "Plan of Care," last revised on April 2018, which stated the PSW will: 1) Access the plan of care for each resident that they are assigned to and/or providing direct care for, 2) Provide care as specified in the resident’s plan of care, 3) Document on the care provided as specified in the plan of care.

Inspector #684 interviewed the DOC regarding the incident involving staff member #134 and resident #011. The DOC indicated that the expectation is that all staff were to follow the resident's plan of care/kardex prior to providing resident care. [s. 6. (7)]

3. A CI report was submitted to the Director, that alleged resident #014 was not provided care as specified in the plan of care and sustained an injury.

Inspector #642 reviewed the home's investigation notes which had identified that PSW #109 and #110, had not provided care as specified in #014's plan of care. The report stated the PSWs were aware that the resident's care plan stated, not to leave the resident alone, while providing specific care but the resident had requested to be left alone. Resident #014 then had a fall while they were alone and sustained an injury.

The Inspector reviewed the home's policy titled, "Plan of Care," last revised in April 2018, which stated the PSWs would provide care as specified in the resident's plan of care.

Inspector #642 reviewed residents #014's electronic care plan, and under a certain focus, the intervention in place at the time of the fall stated, never leave the resident unattended while providing certain care.

Inspector #642 interviewed PSW #109, and #110, who stated that they were required to follow resident #014's care plan and they knew that they should not have left the resident alone while providing certain care.

Inspector #642 interviewed, PSW #146 and RPN #145, who stated that staff are required to provide care to residents as stated in their plans' of care.

The Administrator had provided the Inspector with the investigation documentation related to this incident, which identified that PSW #109, and #110 had received disciplinary action for not providing care as set out in the plan of care for resident #014.

The Inspector interviewed the Administrator, and DOC, who stated the PSWs were to provide care as specified in the plan of care, as all staff were to follow the resident's care plan as required. [s. 6. (7)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

The home submitted a CI report to the Director, indicating that resident #004 had been transferred to hospital due to an injury sustained during a fall. Resident #004 was transferred to hospital for further assessment where they were diagnosed with a certain

injury.

Inspector #647 reviewed resident #004’s clinical records which included the progress notes and the plan of care, which indicated the resident had been identified as a high risk for falls due to specific identified behaviours. As of September 2017, the intervention for a safety device was to be applied to the resident and another safety device was functioning while using their mobility device.

The Inspector reviewed the fall history for resident #004 over a three month period which indicated that resident #004 had four previous falls before the incident, where resident #004 sustained an injury.

A further review of the progress notes from the above mentioned time frame all indicated that resident #004 had removed a certain safety device, that allowed resident #004 to fall out of their mobility device on previous occasions.

Inspector #647 interviewed Registered Nurse (RN) #117, who confirmed that resident #004 was required to have a certain safety device in place when the resident was in their mobility device, however, RN #117 indicated that resident #004 frequently removed the safety device and had falls.

The Inspector interviewed the Assistant Director of Care (ADOC) #111, who confirmed the safety device was a current intervention in the plan of care for resident #004, however acknowledged that the intervention had not been reassessed to evaluate the effectiveness. ADOC #111 indicated resident #004 had removed the safety device which resulted in more falls as indicated above and ended in a serious injury. The ADOC further indicated that resident #004’s plan of care had not been reassessed or revised as the care set out in the plan has not been effective in minimizing resident #004’s falls. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home submitted a CI report to the Director, indicating that resident #001 had a near miss fall resulting in serious injuries.

Inspector #647 reviewed the home's policy titled "Falls Prevention", policy number VII-G-30.00, revised January 2015, which indicated that the home was to complete an electronic post fall assessment by using the post fall huddle or fall incident report.

The Inspector interviewed PSW #108, who stated that after a fall the staff usually complete a post fall huddle. In an interview with RPN #100 they stated that they would usually complete a head to toe assessment of the resident.

Inspector #647 completed a record review for resident #001, that included the progress notes, Minimum Data Set (MDS) and assessments. The review had indicated that an electronic post fall assessment had not been completed using the post fall huddle or fall incident report.

The Inspector interviewed ADOC #111, who acknowledged that an electronic post fall assessment was required to be completed using the post fall huddle or fall incident report, after any resident fall. The ADOC further confirmed, that the post fall assessment had not been completed for resident #001. [s. 49. (2)]

2. The home submitted a CI report to the Director, indicating that resident #007 sustained an injury, cause was unknown. The CI report indicated that resident #007 was assessed by the day RN as the resident had complaints of pain and was then sent to the hospital for assessment. The home was notified that the resident had an injury.

Inspector #647 reviewed the home's policy titled "Falls Prevention", policy number VII-G-30.00, revised January 2015, which indicated that the home was to complete a thorough investigation of a fall incident including all contributing factors and complete an electronic post fall assessment by using the post fall huddle or fall incident report.

Inspector #647 conducted a record review for resident #007, that included the progress notes, MDS data and assessments. Review of resident #007's progress notes stated, the resident had indicated on a certain day, to staff, that they had fallen. The review indicated that an investigation had not taken place relating to the injury with an unknown cause and there were no documents indicating a post fall assessment was completed or a fall incident report.

In an interview with Inspector #647, the ADOC #111 acknowledged that a thorough investigation is to take place after a fall incident is reported and would be required to include contributing factors and the staff are to complete an electronic post fall assessment by using the post fall huddle or fall incident report. The ADOC further confirmed that there was no post fall assessment completed for resident #007. [s. 49. (2)]

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 when a resident has fallen the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: 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 ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A CI report was submitted to the Director, for alleged abuse of resident #010 by staff. The CI report indicated that the incident occurred on a specific day in February, 2018, however the home's management was not informed until eight days after the incident occurred.

Inspector #684 requested the investigation file for this CI report and reviewed a letter with a specific date in February, 2018) which was signed by PSW's # 115, #141, and #149, and RPN #116 that stated eight days prior, these four staff members were aware that resident #010 had not received specific care from the previous shift.

Inspector #684 reviewed the Prevention of Abuse and Neglect of a Resident Policy, #VII-G-10.00, current revision date: January 2015. The policy indicated the following: All employees, volunteers, agency staff, private duty caregivers, contracted service

providers, residents, and families were required to immediately report any suspected or known incident of abuse or neglect to the Director, of the Ministry of Health and Long-Term Care (MOHLTC) and the Executive Director/Administrator or designate in charge of the home.

Inspector #684 interviewed PSW #115, who indicated that a co-worker went to assist resident #010, with care and when they got in the residents room, they found resident #010 had not been provided any care for a significant period of time. The Inspector asked PSW #115 when management was made aware of the incident, PSW #115 indicated probably a week later and unsure as why it was reported so late.

Inspector #684 interviewed RPN #116 who stated the process they would follow when suspected resident abuse had occurred was to report to the RN, document everything, and then inform management, call the Power of Attorney and the Physician if needed. The RPN stated, a PSW asked them to go into the room to observe resident #010, and then all (RPN and PSWs) provided care to the resident. The RPN #116 provided a letter days after the incident, which all the staff involved had signed, and then sent the letter to the Nurse Manager (#114). RPN #116 indicated they were not sure if they had reported the incident to the RN on duty, that day, that it occurred.

During an interview with RN #117 they stated that they had worked on the day of the incident, but nothing unusual was reported to them on that shift.

Inspector # 684 interviewed Registered Social Service Worker #123, who was involved in the investigation of this incident, indicated that they were not informed of the incident until eight days after the incident date.

During the Interview with the Administrator, they confirmed RPN #116, did not report this incident immediately on the day it happened, this incident was reported eight days later, therefore the policy to promote zero tolerance of abuse and neglect was not complied with. [s. 20. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included:
• any mood and behaviour patterns, including wandering
• any identified responsive behaviours
• any potential behavioural triggers and variations in resident functioning at different times of the day.

The home submitted a CI report to the Director, related to alleged resident to resident sexual abuse. A review of the CI report indicated that PSW #147 had witnessed resident #024 involved in a sexual act with resident #025.

Inspector #647 reviewed the plan of care for resident #024 which failed to identify resident #024's responsive behaviours. The plan of care did not include any mood and behaviour patterns, did not identify responsive behaviours or any potential behavioural triggers and variations in resident functioning at different times of the day.

Inspector #647 reviewed the clinical records which included the progress notes, MDS data, and any other relevant assessments which indicated that resident #024 had been admitted on a specific day, and had been assessed with a cognitive performance score (CPS) which indicated that resident #024 had severe cognitive impairment.

The Inspector did a review of the progress notes from the time the resident had been admitted to the time of the above mentioned incident. There had been two previous occasions where resident #024 had exhibited responsive behaviours.

Inspector #647 reviewed the home's Responsive Behaviours-Management Policy, last revised on March 2018, which identified the resident should have a responsive behaviour individualized plan of care.

During interviews with PSW's #129 and #130, RPN #131, and Social Worker (SW) #123, they all acknowledged that resident #024 had responsive behaviours.

During an interview with DOC #113, they indicated that resident #024 exhibited responsive behaviours and acknowledged the previous incidents where resident #024 had demonstrated responsive behaviours. The DOC confirmed that the plan of care did not identify the residents responsive behaviours. [s. 26. (3) 5.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A CI report was submitted to the Director, related to alleged staff to resident abuse. PSW #134 was observed and was reported as being rough with resident #011, to the point the resident was complaining of pain after the incident.

Inspector #684 interviewed PSW #134 who indicated that, resident #011 was scheduled to have a bath. PSW #134 stated that they did not have a chance to complete resident #011's bath. The Inspector asked if they had provided a bath that day, and PSW #134 admitted they did not provide the bath at all. PSW #134 was also asked if they documented this or made anyone aware the bath was not given, they answered, "No."

Inspector #684 reviewed the Hygiene, Personal Care and Grooming policy, #VII-G-10.50, current revision January 2015, which indicated under the Bathing section: Provide a minimum of two baths per week. Further, the PSW will, document all hygiene and grooming, including bathing and skin care routines, oral, and nail care on the home's specific documentation record.

Inspector #684 reviewed the Bath Schedule which indicated that resident #011 was to be bathed on specific days. The care plan for resident #011 was reviewed by Inspector #684 and indicated that resident #011 requires limited assistance with shower twice weekly and as necessary.

The Inspector reviewed documentation from Point of Care (POC), it was noted that PSW #134 had signed for a bath for resident #011, but the bath was not given.

Inspector #684 interviewed the DOC, who stated that after their investigation and interview for this CI report, they identified that PSW #134 had signed for a bath for resident #011, but had not given the bath. Therefore, they were not aware that the resident had missed a bath therefore no other bath was provided. [s. 33. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of a between-meal beverage in the morning.

A CI report was submitted to the Director, that indicated resident #013 was found just before noon in their room on the floor, and the resident had been, upset and crying. In the CIS report the resident stated that they had not been attended to since after breakfast.

Inspector #642 reviewed the home's investigation notes which identified that PSW #132, had been assigned to provide beverages from the snack cart at 1000 hours. PSW #132 had stated in the investigation document that they had knocked at resident #013's door, but did not enter the room to offer a beverage.

Inspector #642 interviewed PSW #132 and they stated that they had not offered a between meal beverage at the morning snack cart pass at 1000 hours for resident #013.

The Inspector reviewed the investigation documents, which stated that PSW #132 had received disciplinary action for not providing a between meal beverage off the snack cart.

Inspector #642 interviewed PSW #129, and PSW #133, who stated that they are required to enter each resident's room daily to offer a beverage or a snack from the morning snack cart.

Inspector #642 reviewed the home's policy titled, "Snack Service," dated January 2015, and under the procedure for the PSW's, they are to provide snacks and fluids according to resident's personal diet information on the diet type report/electronic dining report using the therapeutic menu as a guide to what is to be offered or served at that meal or snack time.

The Inspector interviewed the Administrator, who stated that PSW #132 did not go into resident #013's room, to offer the resident a morning beverage off the snack cart, all residents are to be offered a between-meal beverage in the morning, afternoon and a beverage in the evening after dinner. [s. 71. (3) (b)]

Issued on this 12th day of October, 2018

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) :	AMY GEAUVREAU (642), JENNIFER BROWN (647), SHELLEY MURPHY (684)
Inspection No. / No de l'inspection :	2018_669642_0019
Log No. / No de registre :	001806-17, 003203-17, 004729-17, 004942-17, 005190-17, 006116-17, 008119-17, 008900-17, 011519-17, 013631-17, 014611-17, 020930-17, 024504-17, 028070-17, 001077-18, 002587-18, 003958-18, 004254-18, 004783-18, 006065-18, 006604-18, 007627-18, 008057-18, 008919-18, 009570-18, 014879-18, 014890-18, 015010-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 9, 2018
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Muskoka Shores Care Community 200 Kelly Drive, GRAVENHURST, ON, P1P-1P3

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Angela Coutts

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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) (a)

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

Specifically the license must:

a) Ensure that residents #004's fall prevention interventions are implemented as specified in the plan of care,

b) Ensure that resident #014 are not left alone as specified in their plan of care and monitoring and interventions are implemented, and

c) Ensure that resident #011's mobility interventions are implemented as specified in the plan of care.

d) Develop and implement an auditing system to ensure the provision of care is consistent with the resident's plan of care. The system must include a documented process that identifies when deficiencies are identified, and how they were corrected.

Grounds / Motifs :

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

A CI report was submitted to the Director, that alleged resident #014 was not provided care as specified in the plan of care and sustained an injury.

Inspector #642 reviewed the home's investigation notes which had identified that PSW #109 and #110, had not provided care as specified in #014's plan of care.

The report stated the PSWs were aware that the resident's care plan stated not to leave the resident alone, while providing specific care but the resident had requested to be left alone. Resident #014 then had a fall while they were alone and sustained an injury.

The Inspector reviewed the home's policy titled, "Plan of Care," last revised in April 2018, which stated the PSWs would provide care as specified in the resident's plan of care.

Inspector #642 reviewed residents #014's electronic care plan, and under a certain focus, the intervention in place at the time of the fall stated, never leave the resident unattended while providing certain care.

Inspector #642 interviewed PSW #109, and #110, who stated that they were required to follow resident #014's care plan and they knew that they should not have left the resident alone while providing certain care.

Inspector #642 interviewed, PSW #146 and RPN #145, who stated that staff are required to provide care to residents as stated in their plans' of care.

The Administrator had provided the Inspector with the investigation documentation related to this incident, which identified that PSW #109, and #110 had received disciplinary action for not providing care as set out in the plan of care for resident #014.

The Inspector interviewed the Administrator, and Director of Care (DOC), who stated the PSWs were to provide care as specified in the plan of care, as all staff were to follow the resident's care plan as required. (642)

2. The home had submitted a CI report to the Director, which alleged staff to resident abuse. PSW #134 was observed and was reported as being rough with resident #011, and had moved the resident faster than necessary, to the point the resident was complaining of pain after the incident.

Inspector #684 reviewed the home's investigation notes which indicated that PSW #134, admitted they had not read resident #011's care plan/kardex as required, to ensure they were providing the correct care to resident #011.

The Inspector reviewed the care plan for resident #011, which stated the

following: I use a mobility device. I can move myself but I like when people help me with my mobility device as well. I also use another mobility device within my room with a team member's assistance x 1."

During an interview with PSW #134, they had told Inspector #684 that they usually looked at the kardex at the start of their shift to know what care the residents required. PSW #134 indicated that they had provided care to resident #011 and were unaware that the resident's care status had changed and the resident now required a different mobility device for mobility. Inspector #684 asked PSW #134 if they had checked resident #011's plan of care at the start of the shift, the day of the incident, and the PSW indicated, "no" they had not.

Inspector #684 reviewed the policy titled, "Plan of Care," last revised on April 2018, which stated the PSW will: 1) Access the plan of care for each resident that they are assigned to and/or providing direct care for, 2) Provide care as specified in the resident's plan of care, 3) Document on the care provided as specified in the plan of care.

Inspector #684 interviewed the DOC regarding the incident involving staff member #134 and resident #011. The DOC indicated that the expectation is that all staff were to follow the resident's plan of care/kardex prior to providing resident care. (684)

3. The home submitted a CI report to the Director, indicating that resident #004 was found on the floor, with no mobility safety device functioning. Resident #004 was transferred to the hospital for further assessment where they were diagnosed with an injury.

Inspector #647 had reviewed resident #004's clinical records which included the progress notes and the plan of care. The records indicated the resident had been identified as a high risk for falls due to behaviours. The resident had an intervention put in place, on a day in September 2017, to ensure the safety device was applied to resident #004 when they were up in their mobility device. The progress notes indicated that when the resident had been found on the floor, the mobility safety device was not functioning.

The Inspector interviewed PSW #126, who indicated that they had been working at the time of the incident, when resident #004 required the mobility device due to their high risk of falls. PSW #126 further indicated that when the resident was

observed after the fall, the mobility safety device was not functioning.

Inspector #647 observed resident #004 on a day in July, 2018, with a certain mobility safety device in place, and a second safety device in place. Upon closer observation, Inspector #647 observed resident #004's mobility safety device was not functioning. PSW #127 confirmed at the time of this observation that the mobility safety device was not functioning to ensure resident safety and as directed by the resident's plan of care.

During an interview with the DOC, they indicated that the plan of care for resident #004 at the time of the incident, had not been followed as the mobility safety device had not been functioning and the plan of care continued to not be followed, as evidenced by the Inspector's observation on a day in July, 2018.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 3 as it related to three out of three residents reviewed. The home had a level 3 compliance history as they had previous non-compliance with this section of the LTCHA that included:
-written notification (WN) issued October 6, 2016 (2016_514566_0017)
-voluntary plan of action (VPC) issued October 6, 2016 (2016_514566_0017)
-compliance order (CO) issued November 24, 2016, (2016_535557_0016) complied November 2017. (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 02, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Amy Geauvreau

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