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 prévue 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2019	2019_680687_0007	007499-19, 008414-19	Complaint

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

LOVIRIZA CALUZA (687)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 29 to May 3, 2019 and May 6 to 10, 2019.

The following intake was inspected during this Complaint Inspection:
-One intake related to care concerns of a resident who sustained an injury after a fall.

A Critical Incident System (CIS) inspection #2018_680687_0008 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Nurse Managers (NM), Registered Nurses (RNs), Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses (RPNs), Physiotherapist (PT), Occupational Therapist (OT), Resident Relations Coordinator, Personal Support Workers (PSWs), Ward Clerk, residents and family members.

The Inspector also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed resident's health records, staffing schedules, internal investigations and the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Snack Observation

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

- **2 WN(s)**
- **2 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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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 staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A complaint was submitted to the Director on a specified date in 2019, related to care concerns of resident #001 who sustained an injury after a fall.

Inspector #687 conducted a record review of resident #001's electronic care plan where it was identified that the resident was assessed as a specific risk for falls on specified dates.

In a record review of resident #001's electronic Physiotherapy (PT) Assessment, Inspector #687 identified that the resident was assessed at a different risk for falls based on the Tinetti Score on specified dates.

A review of the home's policy titled "Falls Prevention" last revised on January 2015, indicated that, "Each member of the interdisciplinary team (Registered staff, PT, Occupational Therapy [OT], and Recreation) would complete their respective assessments and discuss the appropriate interventions with the multidisciplinary team".

Inspector #687 interviewed PSW #109 who stated that resident #001 did not sustain any fall incidents since their admission and had no falls interventions in place prior to the date of their fall. The PSW stated that resident #001 was identified as a specific risk for falls (the fall risk identified in the resident's electronic care plan).

In an interview conducted by Inspector #687 with RN #112, the RN stated that resident #001 was at risk for falls but was uncertain of the resident's identified fall risk level.

During an interview with PT #114, they verified that resident #001's electronic care plan record under the focus "Physio", identified resident #001 was categorized as a specific risk for falls (different than what was identified by the nursing staff) on specified dates which were based on the outcome measures of the Tinetti Score. The PT stated that they did not personally communicate resident #001's physiotherapy assessments to the nursing staff as their physiotherapy assessments were accessible to the rest of the team.

In an interview conducted by Inspector #687 with the Resident Assessment Instrument (RAI) Coordinator/ADOC #1, they verified that the Physiotherapy Assessments on specified dates indicated that resident #001 was categorized as a specific risk for falls under the focus "Physio" in the resident's electronic care plan record. However, under the focus "Risk for Falls", resident #001 was categorized differently for their risk for falls which was created and revised by the nursing staff from specified dates. The RAI Coordinator/Associate DOC further stated that the PT should have communicated their physiotherapy assessments with the nursing department in accordance to the home's Falls Prevention Policy. The RAI Coordinator/ Associate DOC further stated that they recognized that there were inconsistencies in the resident's focus for the risk for falls in the resident's electronic care plan record. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of

care was documented.

A complaint was submitted to the Director on a specified date in 2019, related to care concerns of resident #001 who sustained an injury after a fall.

In an interview conducted by Inspector #687 with the complainant, they indicated that resident #001 was not receiving a specific care intervention and that they were concerned about the resident's comfort.

a) Inspector #687 conducted a record review of the resident #001's electronic progress notes which indicated that on a specified date, the resident sustained a fall; was sent to the hospital, received a medical intervention and was later diagnosed with a specific injury. The resident was re-admitted back to the home on specified date.

In a record review of the home's policy titled "Documentation – Plan of Care" last revised in April 2018, it indicated that "The PSWs would provide care as specified in the resident's plan of care and document on the care provided as specified in the plan of care".

Inspector #687 conducted a record review of the resident #001's electronic Point of Care (POC) documentation record which indicated implementation of a care intervention for every two hours by staff members which was identified for the resident at that time.

In a subsequent record review of resident #001's electronic POC documentation record, the specific care was documented as completed on specified dates and times.

In a further record review of resident #001's electronic POC documentation record, Inspector #687 identified that on specified dates, the resident's specific care task for every two hours was observed with gaps of more than four to ten hours.

During an interview with the PSW #130, they stated that resident #001 required a specific care intervention every two hours. The PSW acknowledged that they had completed the specific care interventions for the resident on specified dates and stated, " We were supposed to document after the resident received [their specific care intervention] or at point of care but sometimes we can't get into our documentation immediately ".

In an interview with the PSW #131, they stated that resident #001 required a specific care intervention every two hours. The PSW further stated that they had completed the

specific care intervention for the resident on specified dates and stated, " I provided [the specific care intervention] for the resident according to the direction in my POC documentation record but I was not able to document at the time the resident had received [the specific care intervention] or at point of care. I know that I am supposed to document at point of care but I did not".

In an interview with the NM #3, they stated that their expectation from their PSW staff members were to document in the POC electronic documentation record as specified in the resident's plan of care. The NM acknowledged that on specified dates, the PSWs did not follow the documentation policy as there were "obvious gaps" in the the POC electronic documentation record regarding the resident's specific care intervention tasks for every two hours.

b) Inspector #687 conducted a record review of the resident #012's electronic Point of Care (POC) documentation record which indicated implementation of a care intervention for every two hours and as needed by staff members which was identified for the resident at that time.

In a subsequent record review of the resident #012's electronic POC documentation record, the specific care was documented as completed on specified dates and times.

In a further record review of resident #012's electronic POC documentation record, Inspector #687 identified that on specified dates the resident's specific care task for every two hours was observed with gaps of more than four hours.

In an interview with the PSW #140, they stated that resident #012 required a specific care intervention every two hours as stated in the resident's plan of care. The PSW acknowledged that they had completed the specific care intervention for the resident on specified dates and stated, " I document when I get a chance as the home area was really busy in the morning and that I can only get into my documentation at specified time. I know that I should be documenting it at the time the resident [received the specific care intervention] but at times it was not possible because of the tasks required in the home area for the residents".

In an interview with the Administrator, they stated that the expectation from the PSW staff members was to document "accurately" in their electronic POC documentation record as specified in the resident's plan of care. The Administrator recognized that on specified dates, resident #012's specific care task every two hours was not documented

"accurately" in the POC electronic documentation record. The Administrator, stated that the PSW did not follow the documentation policy.

c) Inspector #687 conducted a record review of the resident #011's electronic Point of Care (POC) documentation record which indicated implementation of a care intervention for every two hours while in bed and while in their wheelchair was identified for the resident at that time.

In a subsequent record review of resident #011's electronic POC documentation record, the specific care intervention was documented as completed on the specified dates and times.

In a further record review of the resident #011's electronic POC documentation record, Inspector #687 identified that on specified dates the resident's specific care task for every two hours was observed with gaps of more than four hours.

In an interview with the PSW #139, they stated that resident #011 required a specific care intervention every two hours. The PSW acknowledged that they completed the specific care intervention the resident on specified dates and stated, " I documented the resident's [specific care intervention] task at around a certain time as I can't get into my POC documentation at an earlier time due to other residents requiring personal care. I know that I should be documenting it at point of care but sometimes it is not possible because of the task required on the floor for the residents".

In an interview with the Administrator, they stated that their expectation from their PSW staff members were to document "accurately" in their POC documentation record as specified in the resident's plan of care. The Administrator recognized that on specified dates, resident #011's specific care task every two hour was not documented "accurately" in the POC electronic documentation record. The Administrator, stated that the PSW did not follow the documentation policy as expected.

d) Inspector #687 conducted a record review of resident #001's demographic information and identified that the resident was admitted at a specified time. The resident's electronic Care Plan from specific dates indicated that the resident was categorized as a specific risk for falls.

In a record review of the resident #001's electronic Care Plan for a specific period of time, the Inspector did not identify the resident's fall risks focus in the electronic care plan

record.

In a record review of the home's policy titled "Documentation – Plan of Care" last revised in April 2018, which indicated that "The plan of care is inclusive of the resident record, together with the resident chart and electronic health record".

In an interview conducted by Inspector #687 with PSW #109, the PSW stated that resident #001 was at a specific risk for falls and this was care planned.

In an interview with the NM #3, they stated that resident #001's care plan focus for falls prevention was only initiated on a certain date and there was no previous falls prevention focus since the specified time.

In an interview with the RAI Coordinator/ ADOC #1, they stated that the home transitioned from their previous electronic documentation record system which started on a specified date to the current electronic documentation record system in a 90-day transition time frame.

In an interview conducted by Inspector #687 with the ADOC #2, they recognized that resident #001's falls prevention focus for the specific time frame was not entered in the electronic care plan. The ADOC #2 further recognized that resident #001 was at a specific risk for falls since admission and that the home missed to transfer vital information of the resident's electronic care plan documentation record from the previous to the new electronic documentation record system. [s. 6. (9) 1.]

3. 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 the resident's care needs changed or care set out in the plan was no longer necessary.

During an observation on specified date in 2019, Inspector #687 observed resident #001 laying in their bed in their bedroom.

In a record review of resident #001's physician orders sheet on specified date in 2019, the resident was ordered as requiring a specific type of care (different from the type of care they previously required).

Inspector #687 reviewed resident #001's current electronic care plan at that time and was unable to identify a focus for the specified type of care.

Inspector #687 reviewed the home's policy titled, "Documentation-Plan of Care" last revised April 2018, which indicated that "The plan of care would be developed and maintained to reflect the current care needs, goals, and approaches to care and to be reviewed and revised in response to the resident's change in care needs, wishes, preference, and goals of care".

In an interview conducted by Inspector #687 with PSW #136, the PSW stated that resident #001 was ordered a specific type of care.

During an interview with RPN #122, they verified that upon resident #001's return to the nursing home on a particular date, the resident had received an order for a specific type of care.

In an interview with the NM #3, they stated that when the resident #001 had returned to the home on the specified date they were not made aware of the specific type of care that was ordered by the physician. Their expectation was that the registered staff should have updated the electronic care plan of the resident but this did not occur. The NM #3 further stated that the electronic care plan was updated on specified date to reflect the resident's specific type of care [s. 6. (10) (b)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; ensure that the provision of the care set out in the plan of care is documented, and 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 resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that when a resident's pain was not relieved by initial interventions, the resident would be assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A complaint was submitted to the Director on a specified date in 2019, related to care concerns of resident #001 who sustained an injury after a fall.

Inspector #687 conducted a record review of the resident #001's electronic progress notes where it indicated that on a particular date, the resident had a fall and sustained an injury. The resident was re-admitted to the home from the hospital on specified date with a description of the interventions the resident had received while in hospital.

In a record review of resident #001's electronic Medication Administration Record (eMAR) on specified date, Inspector #687 identified that the resident had an order for pain medication every two hours as needed (PRN). The eMAR identified the resident received the medication at a certain time which was documented ineffective.

In a record review of the home's policy titled "Pain & Symptom Management" revised October 2018, it indicated that "Registered staff to monitor and evaluate the effectiveness of the pain medications in relieving the resident's pain using the pain scale in the vitals section of the electronic documentation system".

In an interview conducted by Inspector #687 with RPN #111, they verified that they had provided a pain medication to resident #001 at a certain time and it was ineffective. The RPN further stated they were uncertain if they re-assessed the resident's pain level. RPN #111 stated that they informed RPN #122 about the ineffectiveness of resident #001's pain medication.

In an interview with RPN #122, they stated that they worked on the specified date but

could not recall if RPN #111 provided details of the ineffectiveness of the pain medication that was administered at a certain time to resident #001.

In an interview conducted by Inspector #687 with the ADOC #2, they stated that when a resident required a pain medication, the registered staff would assess the resident's pain using the Pain Assessment in Advanced Dementia (PAINAD) or numeric pain scale prior to the administration of a pain medication. When a pain medication was administered, the registered staff would check the resident's pain level further to evaluate the effectiveness of the pain medication that was administered. If the medication was ineffective, the registered staff must document any pain management alternatives provided to the resident and document this information in the electronic progress notes as part of the home's Pain and Symptom Management policy. [s. 52. (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's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

Issued on this 30th day of May, 2019

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

Original report signed by the inspector.