Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jun 26, 2020	2020_745690_0008	007585-20, 008846-20	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

TRACY MUCHMAKER (690)

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): May 20-22, 2020, May 25-28, 2020, and June 1-4, 2020.

The Following intake was inspected upon during this Critical Incident Inspection:

-One log, which was related to a critical incident that was submitted to the Director related to a resident to resident altercation.
-One log, which was related to a critical incident that was submitted to the Director related to improper/incompetent care of a resident

Complaint Inspection #2020_745690_0007 was conducted concurrently with this inspection.

Follow Up Inspection #2020_745690_0009 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Managers (NM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

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 and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

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

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

1 WN(s)
1 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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who were harmed as a result of a resident's behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

A critical incident (CI) report was submitted to the Director for an alleged resident to resident abuse that occurred on an identified date. The CI report indicated that a staff member witnessed resident #002 engage in an identified responsive behaviour towards resident #003, both residents fell and resident #003 sustained an injury that resulted in a transfer to hospital and a significant change in status.

A review of resident #002's care plan on Point Click Care (PCC), that was in place at the time of the incident, indicated that the resident had a focus for an identified responsive behaviour towards co-residents related to an identified trigger. The care plan further indicated that there were identified interventions in place to manage the identified responsive behaviour related to the identified trigger.

A review of the resident's health records identified a document from an external agency which indicated that resident #002 was referred to the external agency related to identified responsive behaviours towards co-residents and staff. The document indicated an identified trigger for the resident that was related to the actions of co-residents. The

identified document included suggestions to utilize a specified intervention related to the identified trigger. The document indicated that two of the current interventions had minimal effectiveness in managing the identified trigger and resulted in an escalation of the resident's identified behaviours.

During observations by Inspector #690 of the resident’s room on two identified dates, the Inspector observed that one of the identified interventions was not in place as identified in the care plan.

In an interview with Personal Support Worker (PSW) #106, they indicated that they had been working on the day of the incident and witnessed resident #002 exhibiting an identified responsive behaviour towards resident #003 and that both residents fell. PSW #106, could not recall if an identified intervention was in place at the time of the incident. PSW #106, indicated that resident #002 had a history of the identified responsive behaviour towards other resident’s and that the current interventions had little effectiveness in addressing the identified trigger from happening. Together, PSW #106 and Inspector #690 observed resident #002’s room and PSW #106 identified that an identified intervention was not in place and co-residents were at risk of harm by resident #002.

In an interview with PSW #107, they indicated that resident #002 had identified responsive behaviours towards co-residents. PSW #107, indicated that there were identified interventions in place. PSW #107 indicated that they had not seen one of the identified interventions in place for several weeks.

In an interview with Registered Practical Nurse (RPN) #108, they indicated that resident #002 had identified responsive behaviours towards co-residents and had identified interventions in place. RPN #108, indicated that two of the identified interventions were not effective. Together, RPN #108 and the Inspector went to observe resident #002’s room. RPN #108 and Inspector #690, observed that one of the identified interventions was not in place. RPN #108, indicated that there was not any other interventions in place and that there was a risk to the co-resident’s related to the identified trigger.

In an interview with Inspector #690, Nurse Manager (NM) #118, indicated that the home had referred resident #002 to an external agency to assist with managing the residents responsive behaviours. NM #118 indicated that two of the current interventions in place were not effective in managing an identified trigger, and that they were aware of the recommendation for the identified intervention, but had not yet implemented it at the time

of the inspection. NM #118 indicated that there was a risk to co-residents related resident #002's response to the identified trigger.

In an interview with the Director of Care (DOC), they indicated that resident #002 had identified responsive behaviours related to an identified trigger, that the current identified interventions were not effective, and that co-residents were at risk of harm from resident #002 response to the identified trigger. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who were harmed as a result of a resident's behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 30th day of June, 2020

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

Original report signed by the inspector.