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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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
Jul 21, 2015	2015_299559_0010	T-2309-15	Critical Incident System

Licensee/Titulaire de permis

HUNTSVILLE LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

MUSKOKA LANDING
65 ROGERS COVE DRIVE HUNTSVILLE ON P1H 2L9

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

ANN HENDERSON (559)

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 4, 5 and 6, 2015.

The following Complaint Inspection was completed during this inspection: T-2173-15.

During the course of the inspection, the inspector(s) spoke with the administrator, co-director of care (co-DOC), environmental services manager (ESM), housekeeping staff, registered practical nurses (RPN), personal support workers (PSW), resident family services coordinator (RFSC) and nurse manager (NM).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #002, #004 and #005 from physical abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The applicable definition of physical abuse as per O. Reg 79/10 is the use of physical force by a resident that causes physical injury to another resident. The LTCHA, 2007, S.O.2007, s.19.(1) was previously issued as a voluntary plan of correction (VPC) during the Resident Quality Inspection #2014_369153_0011, conducted on August 12, 2014.

Resident #001 was identified on admission, as having a history of responsive behaviours.

Review of progress notes revealed the following:

1-On an identified date, resident #001 and resident #002 were outside the dining room and a verbal and physical altercation occurred. The residents were separated; no injuries occurred and resident #001 was taken to his/her bedroom.

2-On an identified date in the activity room, PSW #107 observed an altercation between resident #001 and resident #004. PSW #107 was able to separate the residents and resident #001 was redirected to his/her room.

3-On an identified date, in the dining room, resident #001 was observed to push resident #002 in an attempt to remove the resident from the dining room. Staff intervened and removed resident #002 from the the dining room.

4-On an identified date, resident #001 was involved in an altercation with resident #002. PSW #104 observed resident #002 sit down in an armchair in the hallway opposite resident #001's room. Resident #001 was upset and stated "do not come into my room". Resident #001 then touched resident #002's arm, resulting in an injury.

5-On an identified date, during meal service in the dining room resident #001 had an altercation with resident #005 and staff intervened.

Interviews with PSW #104, #107 and #108 reveal responsive behaviour incidents are managed as they occur rather than by having strategies put in place.

An interview with the co-DOC confirmed the home had failed to protect resident #002, #004 and #005 from abuse. [s. 19. (1)]

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 protect residents from physical abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Resident #001 was identified on admission, as having a history of responsive behaviours.

Record review revealed resident #001 had exhibited the following twelve documented incidents for responsive behaviours:

1-On an identified date, resident #001 and resident #004 were outside the dining room

where an altercation occurred. The residents were separated; no injuries occurred and resident #001 was taken to his/her bedroom.

2-On an identified date, in the activity room, PSW #107 observed an altercation between resident #001 and resident #004. PSW #107 was able to separate the residents and resident #001 was redirected to his/her room.

3-On an identified date, in the dining room during meal service, resident #001was observed to jump up clenching his/her fist towards resident #004. Staff intervened and asked resident #001 to calm down and eat dinner.

4-On an identified date, resident #001 had been upset during meal service; pouring drinks on the table, pointing and shaking finger at table mate.

5-On an identified date, in the dining room, resident #001 was observed to push resident #002 in an attempt to remove the resident from the dining room. Staff intervened and removed resident #002 from the dining room.

6-On an identified date, on a specific shift resident #001 was observed by staff having raised his/her fist at resident #005, staff intervened and resident #001 was redirected back to his room.

7-On an identified date, resident #001 was involved in an altercation with resident #002. PSW #104 observed resident #002 sit down in an armchair in the hallway opposite resident #001's room. Resident #001 was upset and stated “do not come into my room”. Resident #001 then grabbed resident #002 resulting in an injury.

8-On an identified date, resident #001 was upset at the beginning of a specific shift; threatening staff, wandering and kicking out at the environment. Staff intervened and removed resident #001 to the activity room.

9-On an identified date, resident #001 was upset with resident #005. Staff intervened and redirected resident #001.

10-On an identified date, during a specific shift, resident #001 was wandering in the home area removing wander strips from other residents' doors. Staff intervened and resident #001 was redirected.

11-On an identified date, during a specific shift, documentation described resident #001 as demonstrating responsive behaviours.

12-On an identified date, during meal service in the dining room resident #001 and resident #005 had an altercation. Staff intervened.

Interviews with PSW #104, #107 and #108 reveal responsive behaviour incidents are managed as they occur rather than by having strategies put in place.

A review of the report from the behavioural intervention response team’s (BIRT) assessment on an identified date, revealed recommendations were made for staff to use a specific observation screening tool developed by BIRT immediately when the resident had further responsive behaviours and document any incidents of reactivity by ABC charting. Interviews with RPN #112, PSW #108 and #109 revealed staff were unaware of the observation screening tool or ABC charting. Staff confirmed the observation screening tool and ABC charting had not been completed since an identified date.

An interview with the co-DOC revealed a PIECES assessment had not been completed and resident #001's medications had been slowly decreased. Following the quarterly medication review, a medication was discontinued. On an identified date, resident #001’s medication was increased, as a result of staff reporting a gradual increase in the resident's responsive behaviours.

Review of the policy Resident Rights, Care and Services - Responsive Behaviour - Program, effective date 09/16/2013, directs staff to initiate and complete a PIECES assessment when there is a change in behaviour.

Staff interviews confirmed the observation screening tools were not started when resident #001 exhibited an increase in the responsive behaviours.

An interview with the administrator confirmed resident #001 had not been reassessed when resident #001’s responsive behaviour care needs changed, interventions were not put in place and resident #001's responses were not documented. [s. 53. (4) (c)]

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 for each resident demonstrating responsive behaviours actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Record review and staff interviews revealed the odour had been lingering in a resident's room for an extended period of time. PSW #103 revealed the lingering odour had been recorded in the maintenance book four times and the last entry in February 2015. The ESM confirmed staff had recorded the odour into the maintenance book on more than one occasion.

The administrator's response in 2014, acknowledged there was an odour. A humidifier in an equipment storage room next to the resident's room was considered to be where the odour was coming from. The response further noted the drains and grease traps in the kitchen were on a regular cleaning schedule and should not be the source of the problem.

In February 2015, an entry in the maintenance book on an identified home area, described the odour in the resident's room as foul. This room was currently occupied by two residents. A few days later, the residents moved to a different room, the room was sealed and work commenced. The ESM confirmed the odour was strong.

The ESM confirmed a rusted grease trap in the kitchen was where the lingering odours were coming from and this waste had leaked; causing external soil contamination and a buildup in the walls between the resident's room and the kitchen.

In May 2015, during the inspection there was no obvious odour. [s. 87. (2) (d)]

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 are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

Issued on this 1st day of October, 2015

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

Original report signed by the inspector.