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
Nov 22, 2018	2018_671684_0026	007708-18, 015497-18, 020663-18, 022731-18, 022756-18, 025687-18, 028567-18, 029744-18, 030327-18	Critical Incident System

Licensee/Titulaire de permis

Huntsville Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

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): November 5-9, 2018, and November 13-16, 2018.

The following intakes were inspected during this Critical Incident Inspection:

-On log related to Disease Outbreak;

-Four logs related to falls prevention; and;

-Four logs related to alleged resident to resident abuse.

A Follow Up Inspection #2018_671684_0024, and a Complaint Inspection #2018_671684_0025, were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Staff Educator/Unit Coordinator, Maintenance Manager, Restorative Care Coordinator, Physiotherapist, Registered Nurse Team Lead with Behaviour Support Services (BSS), Community Support Worker with Behaviour Support Services, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

Inspector also conducted daily tours of the resident care areas, observed provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, and resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 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. 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 plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, and any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A CI report was submitted to the Director on a specified date in 2018, for suspected resident to resident abuse between resident #009 and #010. The CI report stated that resident #010 was found with resident #009, and resident #009 informed a staff member that resident #010 was exhibiting inappropriate responsive behaviour towards them.

During a review of resident progress notes Inspector #684 noted that resident #010 had multiple different incidents of inappropriate responsive behaviour documented over the past months.

Inspector #684 reviewed resident #010's care plan and noted that there was no care plan in place for inappropriate responsive behaviours.

Inspector #684 interviewed PSW #111 and RPN #117, who both confirmed that they were aware resident #010 had previous incidents of inappropriate responsive behaviour.

During an interview with PSW #111 they stated there was no care plan for inappropriate responsive behaviour for resident #010 and that their responsive behaviours were becoming more frequent. RPN #117 and Inspector #684 reviewed resident #010's current care plan and confirmed that resident #010 did not have a care plan for inappropriate responsive behaviours.

Inspector #684 reviewed licensee policy titled-Resident Rights, Care and Services-Plan of Care which states: There shall be a written plan of care for each resident that sets out the planned care for the resident, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident.

Inspector #684 interviewed the Acting DOC and asked if there should be assessments and a care plan in place for resident #010's inappropriate responsive behaviours to which they answered yes there should have been. [s. 26. (3) 5.]

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 requirement of this section are met with respect to every plan of care. The plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident, mood and behaviour patterns, including wandering , and any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

Inspector #684 reviewed two Critical Incident (CI) reports which were submitted to the Director on a specified day in 2018, for alleged resident to resident abuse. In one CI report resident #003 was displaying a responsive behaviour towards resident #011 after resident #011 interacted with resident #003. In the second CI resident #003 had an interaction with resident #012, resident #003 then displayed a responsive behaviour towards resident #012 at which time resident #012 displayed a responsive behaviour towards resident #003.

Upon review of resident #003's care plan in place at the time of the inspection, Inspector #684 noted a specific intervention which was to be used for resident #003's responsive behaviours.

During observations on two separate days, Inspector #684 noted that the responsive behaviour intervention that was to be in place for resident #003 was not in use.

Inspector #684 interviewed RPN #112, who stated they had not seen the specified responsive behaviour intervention in use in some time for resident #003. Personal Support Worker (PSW) #113 was also interviewed by Inspector #684 and stated that resident #003 does not currently have the specified intervention in place.

Inspector #684 reviewed the homes policy titled Resident Rights, Care and Services-Plan of Care last revised January 13, 2018, which stated that "Care shall be provided to the resident as specified in the plan of care".

During an observation with the Staff Educator/Unit Coordinator and Inspector #684 regarding resident #003s specified responsive behaviour intervention, the Staff Educator confirmed that the specified intervention was not in place and that care was not being provided as reflected in the current care plan. [s. 6. (7)]

Issued on this 5th day of December, 2018

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

Original report signed by the inspector.