Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jul 12, 2019	2019_680687_0017	031732-18	Critical Incident System

Licensee/Titulaire de permis

Huntsville Long Term Care Centre Inc.
c/o Jarlette Health Services 711 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

LOVIRIZA CALUZA (687)

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 8 to 10, 2019

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

- One intake regarding resident to resident alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Nurse Manager, Environmental Service Manager, Food Service Coordinator, Restorative Care Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Aid (HA), and residents.

The Inspector 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, internal investigation notes, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
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. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that includes, at a minimum, the following element: Providing residents with any eating aids and assistive devices required to safely drink as comfortably and independently as possible.

a) The home submitted a Critical Incident (CI) report to the Director, which indicated an alleged abuse by resident #001 towards resident #002.

Inspector #687 observed resident #001 in the dining room during a specified date. The resident was sharing the same dining room table with resident #003. Resident #003 was observed being served with their fluids during two separate meal services and that no assistive devices were provided.

In a review of resident #003's current electronic care plan, it indicated that staff were to, "Provide [assistive devices] for the resident's fluids".

In a review of the home's policy titled "Resident Rights, Care and Services – Nutrition Care and Hydration Programs – Meal Service" last revised on April 4, 2019, it indicated that the staff were "To ensure that they provide encouragement and assistance according to the resident's plan of care and preferences and to promote his or her safety, comfort, independence and dignity in eating and drinking".

During an interview with PSW #112, they stated that resident #003 does not normally use

an assistive device for their fluids. They further stated that they had checked the resident's care plan which did not indicate that the resident required any assistive device to assist them with their fluid intake.

In an interview conducted by Inspector #687 with RPN #106, they verified that the resident #003 had no assistive device for their fluids on two separate meal services. They further stated that the resident should have been provided with an assistive device to assist them with their fluid intake as stated in the resident's care plan.

During an interview with the Food Service Supervisor (FSS) with Inspector #687, they indicated that resident #003 required an assistive device as it would facilitate easier consumption of all their fluids. The FSS further stated that the staff should have followed what was in the resident's care plan and the home's policy.

b) Inspector #687 observed resident #005 who was being served with fluids in a glass and a specified fluid in an assistive device.

During a review of resident #005's current electronic care plan, it indicated "Request for [specific assistive] device for their fluids".

In a review of the home's policy titled " Resident Rights, Care and Services – Nutrition Care and Hydration Programs – Meal Service" last revised on April 4, 2019, it indicated that meal service will "Respect resident's choice".

During an interview with PSW #016, they stated that resident #005 had only one assistive device for their specific fluid but not for their other fluids.

In an interview conducted by Inspector #687 with RN #115, they stated that resident #005 required an assistive device for the all their fluids and recognized that the resident had only one assistive device for a specific fluid but not with their other fluids. The RN further stated that the resident should have been provided with an assistive device for all their fluids as requested and documented in the resident's care plan.

During an interview with the FSS, they indicated that resident #005 required an assistive device for their fluids at their request. They acknowledged that they also observed that the resident did not have their assistive device for all their fluids on a specified date and meal service. The FSS stated that staff should have provided the assistive device for all of the resident's fluids as requested. [s. 73. (1) 9.]

2. The licensee has failed to ensure that, no resident who required assistance with eating was served a meal until someone was available to provide the assistance required by the resident.

Inspector #687 observed resident #003 sitting at the dining room table with other residents that were eating independently. The Inspector observed the resident for 34 minutes with no staff assistance after they were served with their specified meal:

- At 1222 hours the resident was observed being served with their specified meal,
- At 1256 hours, PSW #108 approached the resident and set aside their specified meal as the resident did not consume any.

In a review of resident #003's current electronic care plan, it indicated that the staff were "To assist the resident with feeding part of their meal as required".

In a record review of the home's policy titled " Resident Rights, Care and Services – Nutrition Care and Hydration Programs – Meal Service" last revised on April 4, 2019, it indicated that the staff were to "Ensure that they provide residents with supervision, encouragement, and assistance with their intake of food and beverages at meals and snack times".

During an interview conducted by Inspector #687 with resident #003, they stated that they did not like their specified meal.

In an interview with PSW #109 by Inspector #687, they verified that resident #003 consumed zero per cent of their specified meal.

Inspector #687 interviewed RPN #106 and they stated that resident #003 was generally independent with their meal; however, a staff member would provide assistance if required.

During an interview with Inspector #687, the FSS indicated that resident #003 required cuing or encouragement during meal service as required. The FSS stated that staff should have approached, encouraged and assisted the resident to consume their specified meal as stated in their care plan and to follow the home's policy. [s. 73. (2) (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 home has a dining and snack service that includes, at a minimum, the following element: Providing residents with any eating aids and assistive devices required to safely drink as comfortably and independently as possible as well as to ensure that, no resident who requires assistance with eating is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: (2) A description of the individuals involved in the incident, including, (ii) names of any staff members or other persons who were present at or discovered the incident.

The home submitted a CI report to the Director, which indicated an alleged abuse by

resident #001 towards resident #002.

In a review of the home's internal investigation, Inspector #687 did not identify the names of any staff members who were present or discovered the alleged responsive behaviour incident of resident #001 towards resident #002.

Inspector #687 reviewed the home's policy titled "Residents Rights, Care and Services – Reporting and Complaints – Critical Incident Reporting" last revised March 15, 2019, which indicated that within 10 days of becoming aware of the incident or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

- A description of the individuals involved in the incident including the names of any staff members or other persons who were present at or discovered the incident.

During an interview with PSW #117, they stated that they were asked to assist with personal care of resident #002 due to an injury that the resident sustained as a result of the alleged responsive behaviour of resident #001 towards resident #002. The PSW further stated that they were not asked to provide any information to any management about this incident.

In an interview conducted by Inspector #687 with RPN #107, they stated that they responded to the alleged responsive behaviour of resident #001 towards resident #002. The RPN further stated that they were not asked to provide details of the alleged responsive behaviour incident of resident #001 towards resident #002 to any management staff.

During an interview with Nurse Manager #102, they stated that they could not locate the internal investigation notes involving the alleged responsive behaviour of resident #001 towards resident #002.

In an interview with the Administrator, they stated that a former ADOC conducted the internal investigation of the alleged responsive behaviour of resident #001 towards resident #002. The Administrator further stated that they could not locate their internal investigation notes of the staff interviews of who were involved or present during the incident of the alleged responsive behaviour of resident #001 towards resident #002. The Administrator acknowledged that they did not follow the CI reporting as outlined in their policy. [s. 107. (4) 2. ii.]

Issued on this 16th day of July, 2019

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

Original report signed by the inspector.