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
Nov 15, 2019	2019_745690_0028	019273-19	Other

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

TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): October 9-11, 2019.

Off-site activities related to this inspection occurred on; October 18, 21, 30, 31, November 1, and 13, 2019.

The following intake was inspected upon during this Other inspection:
-One log which was related to a telephone call the Licensee placed to the Sudbury Service Area Office (SSAO), regarding an incident that occurred related to a family member.

Critical Incident Inspection 2019_745690_0029 was conducted concurrently with this Other inspection.

Inspector #543(Tiffany Boucher) participated in this inspection off-site.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 24 (1), identified in a concurrent inspection #2019_745690_0029 (Log #019290-19, CIS#2840-000030-19) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Ontario Provincial Police (OPP) Sergeant, residents and family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed health care records, internal investigation notes, as well as licensee policies, procedures and programs residents and family members.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A critical Incident (CI) report was submitted to the Director on an identified date, for Unlawful conduct that resulted in harm/risk of harm to a resident, related to an incident that occurred five days earlier.

During a follow up call between Inspector #543 and the Administrator, the Administrator indicated that resident #001's SDM had made allegations of abuse approximately three months prior to the incident mentioned in the CI report. The Administrator further indicated that the home had sent resident #001 for an assessment related to the allegation.

Inspector #690 reviewed the Long Term Care Homes Critical Incident System Reporting portal and did not locate any CI reports submitted by the home for allegations of abuse during the period that the allegation was made.

Inspector #690 reviewed resident #001's electronic progress notes on Point Click Care (PCC) and identified a progress note documented on an identified date approximately three months prior to the date of the above mentioned CI report, that indicated that the resident's SDM reported to the Director of Care (DOC) allegations of abuse towards resident #001. A progress note documented by the Physician on the same identified date indicated that the Physician assessed resident #001 due to the allegation of abuse. The progress notes further indicated that the physician assessed the resident and found no injuries.

In an interview with the DOC, they indicated that the home did not submit a CI report for the allegation of abuse as resident #001's SDM had a history of making allegations and that in the past the allegations were unfounded. The DOC indicated that the home did do an investigation into the allegation, including assessments of the resident. The DOC indicated that the home should have submitted a CI report for the allegation of abuse that resident #001's SDM had brought forward.

In an interview with the Administrator, they indicated that the home did not submit a CI report for the allegation of abuse as they did not think there was reasonable grounds to suspect that the abuse had occurred after the Physician determined that there was no evidence of abuse. The Administrator indicated that the home did do an investigation into the allegation and followed the "decision tree" for licensee reporting of abuse and did not report the allegation to the Director. [s. 24. (1) 2.]

2. The licensee has failed to ensure that any person who had reasonable grounds to suspect that unlawful conduct that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A call was placed to the Sudbury Service Area Office (SSAO) by the licensee's Director of Long Term Care Operations on an identified date, to advise the SSAO of an incident that occurred five days prior to the phone call and subsequent action the home took the day before the phone call.

During a follow up call to the home on an identified date, between Inspector #543 and the Administrator, the Administrator described the incident and the subsequent actions taken by the home to ensure the safety of the residents. Inspector #543 advised the Administrator to submit a CI report related to the incident.

A CI report was submitted to the Director for Unlawful conduct that resulted in harm/risk of harm to a resident, related to the above mentioned incident that occurred six days prior to the day the licensee called the SSAO. The CI report described the incident and the subsequent actions taken by the home to ensure the safety of the residents.

In an interview with Inspector #690, the Administrator indicated that the incident that the CI report was submitted for occurred on an identified date. The Administrator indicated that they had decided to put measures in place to ensure the safety of the residents after becoming aware of further details two days after the incident occurred. The Administrator further indicated that the actions taken by the home were done as a temporary measure to ensure the safety of the residents. The Administrator indicated that the home did not submit the CI report until after the call was placed to the SSAO and the home was instructed by Inspector #543 to submit the CI report. [s. 24. (1) 3.]

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 any person who has reasonable grounds to suspect that abuse of a resident by anyone, or unlawful conduct that resulted in harm or risk of harm to a resident has occurred, or may occur, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 15th day of November, 2019

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

Original report signed by the inspector.