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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 24, 2013	2013_102116_0038	T-447-13	Complaint

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

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 15, 16, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Registered staff, Personal Support workers and residents.

During the course of the inspection, the inspector(s) reviewed the health record of residents, in-service attendance records on prevention of abuse and the homes zero tolerance for abuse policy.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that Resident #1 was protected from abuse.

- Resident #1 is identified with skin integrity issues which include frail, thin skin.
- On a specified date, a Registered staff member was observed in the dining room feeding Resident #1 in an inappropriate manner. The Registered staff was observed to speak to Resident #1 in a harsh tone while attempting to feed the resident his/her meal. Resident #1 was observed pushing the Registered staff members hand away and raised his/her hands to cover his/her mouth in an attempt to refuse the food. Staff members present in the dining room witnessed the Registered staff member holding both of Resident #1's hands against the Resident's chest while placing a spoon towards the resident's mouth. After several attempts to feed Resident #1 were unsuccessful the Registered staff member exited the dining room. Staff members attended to Resident #1 and observed a fresh skin tear to an area on Resident #1's body.
- Interviews held with staff members confirmed that the force used by the Registered staff member to feed Resident #1 was excessive.
- The Registered staff member was disciplined as a result of this incident [s. 3. (1) 2.]

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 Resident #1's right to be protected from abuse is upheld, to be implemented voluntarily.

WN #2: 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 failed to ensure that person(s) who had reasonable grounds to suspect that abuse of a resident that resulted in harm or risk of harm was immediately reported to the Director.

- During the inspection, staff members confirmed to the inspector that an incident which occurred on a specified date was reported to a member of management in the home where a Registered staff member was observed in the dining room feeding Resident #1 in an inappropriate manner.
- During the inspection, staff members and a member of the management team of the home confirmed they did not report the suspicion of abuse and the information upon which it was based to the Director.
- The Administrator and Director of Care reported to the inspector that they did not report the allegation of abuse to the Director [s. 24. (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 ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone that results in harm or risk of harm is reported to the Director, to be implemented voluntarily.

Issued on this 24th day of September, 2013

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