Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 9, 2020	2020_853692_0008	019877-20, 021012-20, 021093-20	Critical Incident System

Licensee/Titulaire de permis

The District of the Municipality of Muskoka
98 Pine Street BRACEBRIDGE ON P1L 1N5

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

The Pines
98 Pine Street BRACEBRIDGE ON P1L 1N5

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

SHANNON RUSSELL (692)

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): October 26-30 and November 2, 2020.

The Following intake(s) were inspected upon during this Critical Incident System Inspection:
-Three logs, which were related to critical incidents that the home submitted to the Director regarding incidents of resident abuse by anyone, causing harm or the risk of harm to the resident.

A Complaint Inspection #2020_853692_0006 and a Follow Up Inspection #2020_853692_0007 were conducted concurrently with this inspection.

Please note: A compliance order related to s. 19 (1) was identified in this inspection and has been issued in Follow Up inspection report #2020_853692_0007, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Dietary Aide (DA), Housekeepers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

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

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
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	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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee failed to ensure that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was reported immediately to the Director.

A Critical Incident System (CIS) report was submitted to the Director related to an incident of alleged resident to resident physical abuse that resulted in an injury to a resident. The incident was not reported to the Director until five days after the incident had occurred. The Associate Director of Care (ADOC) indicated that this incident should have been reported immediately to the Director.

Sources: CIS report; resident progress notes; the home's Zero Tolerance of Abuse and Neglect policy; interviews with the ADOC, and other staff. [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 ensuring that anyone who has reasonable grounds to suspect abuse of a resident immediately reports the suspicion and the information upon which it is based to the Director, 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 the assessments taken in response to residents exhibiting responsive behaviours were documented.

There were two separate incidents of resident to resident physical abuse causing injury to the residents. As a result of these incidents, a specified monitoring process was to be implemented for both residents who had exhibited the responsive behaviours towards the other residents. A review of the documentation for both residents identified that the documentation was incomplete. During separate interviews with the direct care nursing staff, they all indicated that they had completed the specified monitoring process; however, they had not documented, and they should have.

Sources: CIS reports; Responsive Behaviour policy; residents health care records; interviews with the nursing staff. [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 ensuring that for each resident demonstrating responsive behaviours that 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. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that when residents exhibit responsive behaviours towards other residents, strategies were developed and implemented to respond to these behaviours to minimize the risk of harm to residents.

There had been an incident of resident to resident physical abuse causing injury. An identified intervention was to be implemented in order to mitigate the risk of harm from the residents responsive behaviours. During the inspection, the Inspector observed on five separate occasions that the identified intervention had not been implemented. Together, a PSW and the Inspector observed the identified intervention not implemented; the PSW indicated the identified intervention was to be in place at all times.

Sources: CIS report; resident progress notes; Responsive Behaviours policy; Interviews with a PSW and other staff. [s. 55. (a)]

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 ensuring that procedures and interventions are developed and implemented to assist residents who are at risk of harm or who are harmed as a result of a resident's responsive behaviours to minimize the risk of harm to residents, to be implemented voluntarily.

Issued on this 12th day of November, 2020

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

Original report signed by the inspector.