Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
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Original Public Report

Report Issue Date: May 23, 2024.	
Inspection Number: 2024-1575-0001	
Inspection Type: Critical Incident	
Licensee: The District Municipality of Muskoka	
Long Term Care Home and City: The Pines, Bracebridge	
Lead Inspector Amanda Belanger (736)	**Inspector Digital Signature**
Additional Inspector(s) Kaitlyn Puklicz (000685)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8-12, 2024.

The following intake(s) were inspected:
- One intake related to a fall of a resident;
- Three intakes related to disease outbreaks; and,
- Five intakes related to reports of abuse.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that two residents plans of care provided clear direction to staff.

Rationale and Summary
a) A resident was known to display responsive behaviours. The resident's care plan and Kardex provided different time intervals to staff at how frequently to monitor the resident.

The Responsive Behaviour Lead indicated that the plan of care did not provide clear direction to staff, and that it should have provided the same frequency for the checks in both the care plan and Kardex.

Sources: The resident's care plan and Kardex; interview with the Responsive Behaviour Lead, and other relevant staff.

b) The resident care plan provided the staff with direction to monitor the resident at specific intervals, however the Kardex provided a different direction to staff to check the resident "more frequently" at certain time frames, although there was no specified frequencies.

The Falls Prevention and Management Lead indicated that the plan of care for the resident did

not provide clear direction to staff.

Sources: The resident's care plan and Kardex; and, interview with Falls Prevention and Management Lead, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that those involved in the care of the resident collaborated.

Rationale and Summary
A referral was completed for a resident related to falls prevention interventions. The recommendations were received by the home, however, members of the nursing team were not made aware that recommendations had been received, and therefore the recommendations were not trialed.

The Fall Prevention Lead for the home indicated that they were not aware that any recommendations had been received related to the resident, and those involved in the resident's care had not collaborated as they should have.

Sources: The resident's progress notes, and care plan; external resource notes; and interview with the Fall Prevention Lead, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Reporting to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee failed to ensure that allegations related to abuse of resident were reported to the Director immediately.

Rationale and Summary
A review of the resident's progress notes indicated that there had been multiple situations involving the resident that were allegations of resident to resident abuse, that had not been reported to the Director.

The Director of Care (DOC) indicated that the home had investigated the incidents, and did not report the allegations of abuse to the Director.

Sources: The resident's progress notes; licensee policy; and interview with the DOC, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Managing Harmful Interactions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to identify and implement interventions for the resident to prevent potentially harmful interactions with other residents.

Rationale and Summary
A resident had a number of incidents of displaying responsive behaviours towards various co-residents.

A review of the resident's plan of care at the time of the inspection had no interventions identified to manage the resident's behaviours towards other residents.

The DOC reviewed the resident's care plan with the Inspector and acknowledged that there were not interventions in place to manage the resident responsive behaviours towards co-residents.

Sources: The resident's progress notes, and care plan; licensee policy; and interviews with an RPN, DOC, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces.

The licensee has failed to ensure that the housekeeper was cleaning and disinfecting contact surfaces in accordance with the manufacturer's specifications.

Rationale and Summary
A staff member reported that the cleaning product being used had a five minute contact time. However, the Environmental Service Manager (ESM) confirmed that the home used a product with a 10 minute contact time.

Sources: Product instructions, interview with the staff member and the ESM.

[000685]

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
1) Develop a written process to ensure that residents displaying new or worsening behaviours have a behavioural assessment, or reassessment documented;
2) Educate staff with the new process;
3) Develop a designated location for housing the behavioural assessments, reassessments and analysis after completion;
4) Designate a lead to conduct audits to ensure that the process is followed.

Grounds

The licensee has failed to ensure that multiple residents were assessed for their individual responsive behaviours, and the responses to the interventions were documented.

Summary and Rationale

Multiple residents were known to display responsive behaviours. The home was unable to provide any documentation to demonstrate that the behaviours had been assessed for some of the residents. An identified resident had the documentation started, however, it was incomplete, and not analyzed.

The DOC indicated that assessment charting should have been implemented for the residents, and had not been. The Responsive Behaviour Lead indicated that for the identified resident, the assessment had not been completed in its entirely, and had not been analyzed.

Sources: The residents' progress notes, physical chart, assessment tabs, and, assessment charting; the licensee policy, and interview with the Responsive Behaviour Lead, DOC and other relevant staff.

[736]

This order must be complied with by July 26, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (7)
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
1. Working with the interdisciplinary team to implement the infection prevention and control program.
2. Managing and overseeing the infection prevention and control program.
4. Auditing of infection prevention and control practices in the home.
5. Conducting regular infectious disease surveillance.
9. Reviewing any daily and monthly screening results collected by the licensee to determine whether any action is required.
10. Implementing required improvements to the infection prevention and control program as required by audits under paragraph 4 or by the licensee.
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
1) Conduct a documented review of the IPAC Lead's roles and responsibilities within the home;
2) Develop an auditing process to ensure that the responsibilities of the IPAC Lead are met;
3) Develop a documented process within the home to ensure that all recommendations from the Public Health Unit (PHU) are reviewed, discussed, and implemented, as required.

Grounds

The licensee has failed to ensure that the IPAC Lead carried out their responsibilities in the home.

Rationale and Summary

a) During the inspection, it was observed that staff were incorrectly utilizing a disinfectant that the ESM confirmed had a 10 minute contact time.

The IPAC Lead stated that the home had not followed the recommendations provided.

b) During the course of the inspection, the Inspectors observed staff not utilizing the correct Personal Protective Equipment (PPE).

The Inspector requested that the IPAC Lead provide the latest audits related to IPAC processes in the home. The home was not able to provide the audits, or record of actions implemented a result of the outcome of the audits.

c) Upon entry to the home, the Inspectors were informed that a home area had been placed in "Heightened Surveillance".

There was no signage noted on the entry to the home, or the home area, and no indication as to what PPE staff and visitors were directed to utilize.

The IPAC Lead indicated that it was their responsibility to place the signage and this had not been completed.

d) During the course of the inspection, the IPAC Lead was notified of newly symptomatic residents. These new cases were not reported to the PHU until the following day.

The IPAC Lead acknowledged that they should have taken action and called the PHU when residents were noted to have new onset of symptoms.

e) The Inspector requested that IPAC Lead provide the analysis of infection monitoring for the home, based on the daily and monthly surveillance.

The IPAC Lead indicated they did not complete that task.

f) The Alcohol Based Hand Rub (ABHR) in the home was observed to have less than the required 70% alcohol.

The Inspector observed meal service and noted that no hand hygiene was offered to any of the residents prior to eating their meal.

Staff were observed not completing hand hygiene when required.

The IPAC Lead acknowledged that the ABHR did not meet the requirements for the hand hygiene program. The IPAC Lead confirmed that staff were to assist residents with hand hygiene prior to and after meals, and that staff were expected to complete hand hygiene as required.

Sources: Inspector observations; memos to the sector, effective August 2022, and March 4, 2024: PHU reports; licensee policies; The Pines hand over IPAC lead document; home's Specific Outbreak Plan; PHU outbreak report summaries; interview with the PSWs, housekeeper, ESM, PHU Liaison, IPAC Lead, and the Administrator.

[736]

This order must be complied with by July 26, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.