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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 11, 2016	2016_298557_0003	027478-15	Complaint

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 KELLY DRIVE GRAVENHURST ON P1P 1P3

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

VALERIE PIMENTEL (557)

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): February 8, 9, 10, 11, 12, 16, 17 and 18, 2016.

The following Complaint was inspected: Intake Log #027478-15 related to plan of care, responsive behaviors and discharge.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Program Manager (PM), Case Manager (CM), Physician, Physio Therapist (PT), Physio Therapist Assistant (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Substitute Decision Makers (SDM).

The inspector observed staff and resident interactions, observations of the home areas, record review of resident and home records, and reviewed relevant policy and procedures related to the inspection.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
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	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. 6. Plan of care

Specifically failed to comply with the following:

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 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

In September 2015, the Ministry of Health and Long Term Care Infoline received a complaint, in respect to resident #001. The complainant identified that resident #001 was sent to hospital because of escalating behaviors and the staff did not follow the plan of care.

Record review of the focus sections of the written plan of care for resident #001 failed to reveal identified triggers for behaviours identified by an Outreach Team (OT).

The OT recommended interventions were identified, the home's written care plan included three of the twelve noted interventions only.

The transition meeting from the OT to the home was held in March 2014, this meeting was to review the triggers and interventions identified by the OT. The home did not implement all of the collaborative interventions identified.

Staff interviews with CM and an identified DOC confirmed the OT and home's written plan of care were not integrated or consistent with and did not complement each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

In September 2015, the Ministry of Health and Long Term Care Infoline received a complaint, in respect to resident #001. The complainant identified that resident #001 was sent to hospital because of escalating behaviors and the staff did not follow the plan of care.

The complainant stated an incident occurred when an identified staff member entered the bathroom to assist another identified staff member who was in the process of providing activities of daily living (ADL) to resident #001. Resident #001 displayed a responsive behavior by coming in contact with an identified staff member. The complainant indicated the staff did not follow the plan of care which directs staff to have two staff in attendance when ADL are being provided to resident #001, while in the bathroom.

Staff interviews with two identified staff members confirmed they knew to use two staff members while providing identified ADL's but in August 2015, they confirmed they only used one staff member to provide care to resident #001. One of the identified staff further stated the reason this occurred was because one of the identified staff members had to meet the needs of another resident, so one identified staff member continued to provide care independently to resident #001.

Staff interviews with with two other identified staff members confirmed they provided care to resident #001 by themselves and they could manage the resident for the identified ADL.

Interviews with the CM and an identified DOC confirmed the care set out in the plan of care was not provided to the resident #001 as specified in the plan to use two staff members while providing identified ADL to resident #001. [s. 6. (7)]

3. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

In September 2015, the Ministry of Health and Long Term Care Infoline, received a complaint, in respect to resident #001. The complainant identified that resident #001 was sent to hospital because of escalating behaviors and the staff did not follow the plan of care.

Record review for resident #001 revealed a referral was sent to an OT to assess the resident. The reasons for the referral were related to responsive behaviors. The OT initial consultation was in January 2014. OT then observed the resident on nine occasions during January, February and March 2014.

In March 2014, the OT left the following care plan recommendations, on page two of the report, it indicated "please ensure that the following collaborative interventions are added to the resident's care plan". The OT left ten identified collaborative interventions.

Resident #001's behavioral care plan was initiated in December 2013, with a target date of September 2015, to resolve the focus, goal and interventions. The OT collaborative interventions were not implemented into the resident's care plan.

Staff interviews with CM and an identified DOC confirmed that the home had resident #001 assessed between January to March 2014, by the OT but the plan of care was not revised when the resident's needs changed. [s. 6. (10) (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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee failed to before discharging a resident under subsection 145 (1), the licensee shall ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration.

Record review of the plan of care for resident #001 revealed the following:
- In August 2015, resident #001 was admitted to hospital.
- Three days later the substitute decision maker (SDM) came to home to collect a few personal items for resident #001 while the resident was in hospital.
- In September 2015, a meeting was held at the hospital, the "client notes report" from a community agency, identified "Muskoka Shores has decided that they will not take the resident back".
- On the same day, at approximately 5:00 PM, the SDM collected the remaining personal belongings of resident #001.
- Two days later in the census tab of point click care, it indicated resident's discharge date in the month of September 2015.
- The next day the home stopped billing the resident.

An interview with the SDM confirmed that he/she was not made aware prior to the meeting in September of 2015, that the home had planned on discharging the resident and was not given the opportunity to participate in the discharge planning as the home had already made the decision to discharge resident #001. The community agencies senior manager gave the case workers and hospital direction on how to proceed with the application process for other long term care facilities. The SDM's wishes were not taken into consideration in regards to discharging resident #001 from Muskoka Shores.

An interview with an identified DOC indicated that there had been some discussion to try to find a home more suitable for resident #001 with the SDM but could provide no evidence to validate this.

Interviews with the CM, DOC and the ED could not disclose as too when the decision to discharge was made nor confirm whom made this decision. They home felt the family was given the opportunity to participate in resident #001's discharge plans at the time the home announced they would not take the resident back. [s. 148. (2) (c)]

2. The licensee failed to before discharging a resident under subsection 145 (1), the licensee shall provide a written notice to the resident, the resident's substitute decision-

maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident’s condition and requirements for care, that justify the licensee’s decision to discharge the resident.

Record review of the home’s business file and plan of care for resident #001 revealed the home did not give a written notice to the SDM.

An interview with the CM and ED confirmed they did not give a written notice of discharge to either the resident or the SDM providing information as to the setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident’s condition and requirements for care, that justify the licensee’s decision to discharge resident #001. [s. 148. (2) (d)]

Issued on this 25th day of August, 2016

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

Original report signed by the inspector.