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 26, 2019	2019_782736_0031	019078-19	Critical Incident System

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 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

AMANDA BELANGER (736)

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): November 18-20, 2019.

Off-site activities related to this inspection occurred on November 21, and 22, 2019.

During the inspection, the following log was inspected:
-one log submitted to the Director for an allegation of staff to resident neglect.

Follow Up Inspection #2019_782736_0030 was conducted concurrently with this Critical Incident Inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care(s) (ADOCs), Nurse Manager(s), Environmental Services Manager (ESM), Registered Nurse(s)(RNs), Registered Practical Nurse(s)(RPNs), Call bell technician, and residents.

During the course of the inspection, the Inspector observed the provisions of care, tested the home's internal call bell system, reviewed relevant health care records, internal investigation notes and relevant policies and procedures of the licensee.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse was complied with.

A Critical Incident (CI) report was submitted to the Director related to an allegation of staff to resident neglect of resident #002. The CI report indicated that the resident disclosed that they had rang their call bell and it was not answered until near the end of the shift. The CI report further indicated that based on the home's call bell report, the call bell was activated at a specified time on a specific date and was not acknowledged until a specified time.

Inspector #736 reviewed the internal investigation notes provided by the home, which indicated that Personal Support Worker (PSW) #105 and Registered Practical Nurse (RPN) #106 were interviewed in relation to resident #002's complaint of neglect. In the interview notes with RPN #106, they indicated to Associate Director of Care (ADOC) #103 and Nurse Manager (NM) #102 that they were aware that on a specified date and time, that resident #002 indicated that their call bell had been ringing during the specific shift and no one had assisted them. RPN #102 further indicated during the interview that this would have been considered an allegation of neglect. When asked by ADOC #103 and NM #102, RPN #102 indicated that they had not complied with the home's zero tolerance for abuse policy.

A review of the policy titled "Prevention of Abuse and Neglect of a Resident", policy #VII-G-10.00, last revised April 2019, indicated that any team member who witnessed, or had knowledge of an incident that constituted resident abuse or neglect was to immediately stop the situation; remove the resident from the abuser, or remove the abuser from the resident; and, immediately inform the Executive Director and/or Nurse in charge in the care community. The policy further indicated that the nurse was to assess the resident's condition for safety and emotional and physical well being.

In an interview with RPN #106, they indicated to the Inspector that when they became aware that resident #002 had told staff that their call bell had been ringing all shift, they administered a specified treatment, as per the resident's request, but did not follow the home's policy in relation to an allegation of neglect. The RPN indicated to the Inspector that they should have complied with the home's zero tolerance of abuse policy.

In separate interviews with ADOC #103 and the Director of Care (DOC), they both indicated to the Inspector that RPN #106 did not comply with the home's zero tolerance of abuse policy, once they were aware that resident #002 had indicated that they thought

their call bell had been ringing all shift and that they had not been attended to. Both the ADOC and DOC further indicated to the Inspector that the RPN should have complied with the policy. [s. 20. (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 the home's zero tolerance of abuse and neglect policy is complied with, to be implemented voluntarily.

Issued on this 26th day of November, 2019

[redacted]

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

Original report signed by the inspector.