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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 26, 2020	2020_745690_0007	004370-20	Complaint

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

TRACY MUCHMAKER (690)

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): May 20-22, 2020, May 25-29, 2020, June 1-4, June 9-12, and June 16-19, 2020.

The Following intake was inspected upon during this Complaint Inspection:
-One log, which was related to a complaint that was submitted to the Director related to resident care concerns.

Critical Incident System Inspection #2020_745690_0008 was conducted concurrently with this inspection.

Follow Up Inspection #2020_745690_0009 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Director of Resident Relations, Nurse Managers (NM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, 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 interactions and resident to resident interactions, reviewed relevant health care records, the home's complaint log, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Medication
Pain
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the care plan was documented.

A complaint was submitted to the Director related to care concerns of resident #001.

A review of resident #001's health record identified a document that indicated that the resident was to receive the following medications at specified times

-An identified medication to be applied transdermally four times a day to an affected area.
-An identified medication by mouth four times a day.
-Two other identified medications by mouth two times a day.

A review of the resident electronic medication administration record (emar), indicated that the resident was to receive the identified medication to be applied transdermally four times a day at scheduled times. A further review of the emar identified that there was no documentation to indicate that the identified medication was applied five days in March 2020, four days in April 2020, and six days in May 2020 during one of the scheduled times. A further review of the emar for resident #001 for one of the identified months, indicated that the resident was to receive an identified medication, by mouth four times a day at specified times, and two other medications twice a day at specified times. There was no documentation to indicate that the resident received the three medications on an identified date at one of the specified tines.

In an interview with Registered Practical Nurse (RPN) #120, indicated that resident #001 was to receive an identified medication to be applied transdermally four times a day along with other medications to manage their pain. RPN #120 indicated that they were to check the resident's medication orders on the emar, and administer the medications as they were prescribed and then document on the emar to indicate that the medications

had been administered. Together, Inspector#690 and RPN #120 reviewed the emar records for resident #001 for the month of March 2020, April 2020, and May 2020. RPN #120 identified that they had been the RPN working on the days and times that there was no documentation for the administration of the four identified medications for the above mentioned times. RPN #120 indicated that they would administer the scheduled medications with the resident's meal and then go afterwards to apply the identified transdermal and had forgotten to document on the emar. RPN #120 indicated to the Inspector that they were sure they had administered the other medications on the identified date and forgot to sign the emar to indicate it had been given. RPN #120 indicated that all medications were to be documented on the emar once they were administered to indicate that they had been given.

In an interview with the Director of Care (DOC), they identified that all medications were to be given as prescribed by the Physician and documented accordingly on the emar. The DOC further indicated that there should be no blank spots on the emar and that if a medication was not given due for any reason, then the staff were to document with a corresponding code to indicate why the medication wasn't given. Together, the Inspector and the DOC reviewed the emar documentation for resident #001 for the month of March, April and May 2020 and the DOC indicated that there was missing documentation for the identified medications on those dates and times and that there should not have been. [s. 6. (9) 1.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that was reported, was immediately investigated.

A complaint was submitted to the Director for multiple care concerns related to resident #001. The complainant alleged that the resident notified them that an incident took place regarding an identified piece of equipment and that the resident had requested assistance from staff. The complainant alleged that a staff member was physically and verbally abusive to the resident.

In a review of electronic progress notes on Point Click Care (PCC), a progress note documented on an identified date, indicated that the Director of Resident Relations received a voice mail message from the complainant regarding the incident. The progress note further identified that the Director of Resident Relations went and spoke to the resident regarding the incident, and that the resident indicated that the incident with the identified piece of equipment did not occur. The progress note also indicated that the Director of Resident Relations followed up with the complainant and indicated that the incident did not occur.

A review of the home's policy titled "Prevention of Abuse and Neglect of a Resident-VII-G-10.00", last revised April 2019, indicated that the Executive Director (ED) or designate would initiate an investigation by requesting that anyone aware of or involved in the incident would, write, sign and date a statement accurately describing the event. If

statements had been written, the ED or designate would interview those persons, as close to the time of the event as possible. The policy further indicated that all investigative information is to be kept in a separate report from the resident's records.

In an interview with the Director of Resident Relations, they indicated that they had received the voice mail message from the complainant regarding the incident and that they went and spoke with the resident right away. The Director of Resident Relations indicated that they did not speak to any staff or report the allegation to anyone, and that they thought they had addressed the concern by speaking to the resident.

In an interview with Assistant Director of Care (ADOC) #127, they indicated that when there was any allegation of abuse, that the home would investigate the allegation, including speaking with any staff involved, and documenting the conversation in a complaint folder. The ADOC indicated that they had been made aware of the incident, but was not aware of the abuse allegation. Together, the Inspector and ADOC#127, reviewed the progress note on PCC, and the ADOC indicated that the allegation should have been investigated fully and that it was not.

In an interview with the DOC, they indicated that any allegations of abuse were to be investigated, including interviewing any of the staff involved and documenting the interviews. The DOC indicated they were not aware of the allegation of abuse, and that there were no investigation notes related to the incident. Together, the DOC and the Inspector reviewed the progress note on PCC, and the DOC indicated that the allegation should have been immediately investigated, including interviewing staff involved to get more information and documenting the investigation separate from the resident's clinical records. [s. 23. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

A complaint was submitted to the Director related to multiple concerns related to the care of resident #001 and the homes response to the concerns.

The Inspector requested the home's concern and complaint logs for the current year up to the date of the inspection from the ED. The Inspector reviewed a document that was titled "2020 ON WOR Report". The Inspector could not identify any information on the report related to resident #001. The Inspector requested any other documents related to the concerns brought forward by the complainant. The ED provided the Inspector with an identified document related to a meeting that took place on an identified date from the resident's health records. No other documents were provided.

A review of the home's policy titled "Complaints Management Program (ON), #XXIII-E-10.00, last revised, June 2019. The policy indicated that the ED, would identify the complaint, document the investigation and follow up actions in the Weekly Operational Review (WOR) complaint tab.

In an interview with the home's ED, they indicated that the home's Director of Resident Relations was following up with the complainant on a regular basis and documenting in PCC. The ED indicated that the complaint was on-going and there were too many concerns to document them all in the WOR report. The ED further indicated that they had also verbally responded to the complainant and that they had not entered any information on the WOR related to the on-going concerns of resident #001. [s. 101. (2)]

Issued on this 30th day of June, 2020

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

Original report signed by the inspector.