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
Jul 30, 2020	2020_782736_0015	002707-20, 004942-20, 007162-20, 011439-20, 012435-20	Critical Incident System

Licensee/Titulaire de permis

Huntsville Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Muskoka Landing
65 Rogers Cove Drive HUNTSVILLE ON P1H 2L9

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

AMANDA BELANGER (736), 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): July 20-23, 2020.

During the course of this inspection, the following logs were inspected:
-one log related to a report submitted to the Director by the home for an allegation of resident to resident abuse;
-one log related to a report submitted to the Director by the home for a resident elopement of less than three hours;
-one log related to a report submitted to the Director by the home for an allegation of improper or incompetent care of a resident; and,
-two logs related to reports submitted to the Director by the home for a resident fall that resulted in a transfer to hospital and significant change in status for the resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Regional Manager of Environmental Services for Superior, Restorative Care Coordinator (RCC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Personal Support Assistants (PSAs), and residents.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

6 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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 24-hour admission care plan identified the resident, and must include at a minimum, any risks the resident may pose to others, including any potential behavioural triggers and safety measures to mitigate those risks.

A Critical Incident (CI) report was submitted to the Director, related to resident #003 who had been missing from the home for less than three hours. Inspector #692 reviewed the CI report, identifying that before the incident where resident #003 eloped from the home that they had been observed displaying specific behaviours. The CI report further described the events leading up to the elopement.

During a review of resident #003's health care records, Inspector #692 identified a document from an external agency. The assessment indicated that resident #003 had exited their previous living arrangements, which caused concern, requiring admission to Long Term Care (LTC).

A review of their progress notes identified an admission note, which indicated that the resident had eloped from their previous living arrangement. A further review of the progress notes identified an incident note after the LTC elopement, documented by Registered Practical Nurse (RPN) #110, that indicated the resident had been identified as exhibiting a specific responsive behaviour. The physician documented after the incident, that resident #003 had been known to display a specific responsive behaviour where they previously resided.

Inspector #692 reviewed a specific home policy which indicated the plan of care was to be developed and implemented with specific approaches and goals for residents who exhibited specific behaviours.

The Inspector reviewed resident #003's current plan of care and identified a specific focus, that included goals and interventions to mitigate the risk of the specific responsive behaviour; however, it not been created until after the resident had successfully eloped from the home. There had not been a focus identifying that resident #003 was known to display a specific responsive behaviour risk at the time of admission.

During separate interviews with Personal Support Worker (PSW) #116, RPN #110 and Registered Nurse (RN) #111, they all indicated that resident #003 had a history of of the specific responsive behaviour and was at risk when they had been admitted. PSW #116, RPN #110 and RN #111 identified that after admission to the home resident #003 had been observed, on multiple occasions, displaying specific responsive behaviours. They all indicated that the identified specific responsive behaviour risk should have been added to the resident's care plan at the time of admission, and it had not been.

Inspector #692 interviewed the Administrator and the Director of Care (DOC), they both identified that resident #003 had been identified as having had a specific responsive behaviour risk at the time of their admission, based on their previous successful elopement attempts from the residence they at resided prior to admission. They both indicated that resident #003's care plan should have had a focus identifying this risk upon admission, and was not created until after the resident had successfully eloped from the home [s. 24. (2) 2.]

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 24-hour admission care plan identifies any risk the resident may pose, including any potential behavioural triggers and safety measures to mitigate those risk, 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 for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

A CI report was submitted to the Director, related to resident #003 who had gone missing for less than three hours. Inspector #692 reviewed the CI report, identifying that on a specified date, a specific intervention was to be implemented for resident #003.

Please see WN #1 for further details.

Inspector #692 reviewed resident #003's health care records, identifying a progress note, documented eight days later, the Resident Family Services Coordinator (RFSC), that indicated the specified intervention from the CI report had been implemented the previous day.

At the time of the inspection, the Inspector observed resident #003 and their surroundings, identifying the specified intervention from the CI report. The Inspector identified the specified intervention was not properly implemented.

During an interview with the Regional Manager for Environmental Services, they indicated to Inspector #692 that the previous Environmental Services Manager (ESM) had been requested to apply a specific intervention. They indicated that the previous ESM had confirmed to them that they had applied the intervention when requested. The Regional Manager for Environmental Services indicated that they had reapplied the

intervention, ensuring it was effective, immediately after it was brought to the Administrator's attention by the Inspector.

Inspector #692 interviewed the Administrator, who indicated, that they had requested the previous ESM to implement a specific intervention, and that the ESM had confirmed to them that it had been completed. The Inspector identified to the Administrator that the intervention was not implemented as it should have been. The Administrator indicated that the specified intervention was to mitigate the risk of resident #003 eloping, and it had not been implemented. [s. 53. (4) (b)]

2. The licensee has failed to ensure that for each resident that demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident’s responses to interventions were documented.

A CI report was submitted to the Director, related to resident #003 who had gone missing for less than three hours.

Please see WN #1 for further details.

A review of the CI report identified to Inspector #692 that a specified type of assessment was initiated to assist the home with monitoring resident #003’s responsive behaviours.

Inspector #692 reviewed resident #003’s health care records, identifying a progress note, documented by RN #111, that the specified type of assessment had been initiated due to the resident’s elopement risk. A further review of the progress notes, identified a physician note,at a later date, that the resident had been on a specified type of assessment and that they would review the specified type of assessment report when it was available.

The Inspector located the specified type of assessment documents for resident #003, from period of 14 days, in the resident’s paper chart. Of the 14 days reviewed, 10 of the dates had entries there were blank, with time frames ranging from one hour of missing entries to eight hours of missing entries.

In separate interviews with PSW #116, RPN #110 and RN, #111, they all indicated to Inspector #692 that specified type of assessment would be initiated for a resident at times to be able to identify any trends, patterns and triggers with the residents exhibited

responsive behaviours, as well to be able to implement strategies to mitigate the risk of the behaviours. They all identified that if specified type of assessment was initiated then it was to be completed in its entirety and if there were blank spaces, that would indicate that components of the assessment did not occur at that time period. The Inspector reviewed the specified type of assessment documents with PSW #116, RPN #110 and RN #111, which they all identified that the specified type of assessment for resident #003 had not been completed, and it should have been.

In an interview with the Administrator and the DOC, they indicated to Inspector #692 that the specified type of assessment would be initiated for residents who displayed responsive behaviours as either a nursing measure, or as a physician's order. They both indicated that resident #003 had been placed on the specified type of assessment after the incident of elopement, and when they reviewed the documents, they identified that the specified type of assessment had been incomplete, and it should have been completed in its entirety. The DOC identified that by the specified type of assessment being incomplete they would not have been able to obtain "the best picture" of resident #003's responsive behaviours. [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 to ensure that when a resident is demonstrating responsive behaviours, strategies are developed and implemented in response to these behaviours, and ensure that when a resident demonstrates responsive behaviours, the resident's responses to the interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purpose of section 35 of the Act, that the following devices were not used in the home: (7) Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

A CI report was submitted to the Director, related to an allegation of improper or incompetent care of resident #001. The CI report indicated that on a specific date, resident #001 was found in their bed with a specified item around the resident's specified body area.

Inspector #736 reviewed the investigation notes provided by the home, which included interviews with PSWs #106 and #107, as well as RPN #105. In the internal interview notes with PSWs #106 and #107, the Inspector noted that both staff had indicated that resident #001 had been displaying responsive behaviours during the shift, and that they had used a specified item. The Inspector also noted in the internal interviews with PSWs #106 and #107, as well as RN #118, all staff had indicated that the resident had been provided with assistance for activities of daily living (ADLs) during the shift; and, RN #118 further indicated that at a specific time, they had assisted with the resident's care and did not note a specified item being used to restrict resident #001 at that time.

In separate interviews with PSWs #106 #107, they indicated to the Inspector, that they had put a specified item around resident #001 which was tied behind the resident.

In an interview with Inspector #736, RPN #105 stated that a PSW had come to get them, and requested that they attend resident #001’s room. RPN #105 recalled that when they entered the resident’s room, the resident had a specified item that was tied around them. The RPN indicated to the Inspector that the resident had been restrained to their bed, utilizing a specific item.

In separate interviews with the DOC and Administrator, they both indicated to the Inspector that a specific item was not to be used in the home to restrict a resident’s movement or to restrain a resident. In the same interview with the Administrator, they indicated resident #001should not have had a specific item used in that manner. [s. 112. 7.]

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 sheets, wraps, tensors or bandages are not used in the home, other than for a therapeutic purpose, to be implemented voluntarily.

WN #4: 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. (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 has failed to ensure that the resident was reassessed, and the plan of care was reviewed and revised when the resident's care needs changed, or care set out in the plan was no longer necessary.

A CI report was submitted to the Director, related to resident #003 who had gone missing for less than three hours.

Please see WN #1 for further details.

The CI indicated that a specified intervention was put into place on the same day as a result of the elopement.

Inspector #692 reviewed resident #003's health care records, identifying a progress note, indicating that the intervention that was implemented after the elopement was no longer in place.

The Inspector reviewed resident #003's current plan of care and identified a specific focus, which indicated a specific intervention, which had been created on the day of the elopement.

Inspector #692 observed, at the time of inspection, the intervention no longer in place for resident #003.

During separate interviews with Inspector #692, PSW #116, RPN #110 and RN #111, they all indicted that they would review the residents care plan in order to know what care needs the resident required. They all indicated that they recalled the incident when resident #003 had eloped from the home and that at that time a specific intervention was utilized. RPN #110 and RN #111 both identified that there had been a noted decrease in resident #003 responsive behaviours, therefore the intervention was no longer utilized; however, the care plan had not been revised when that change had been made.

Inspector #692 interviewed the Administrator and the DOC, who both indicated that a resident's care plan should be reflective of their current needs. The Administrator indicated that after resident #003 had eloped from the home, the home implemented a specific intervention, and that intervention was no longer utilized when there had been a decrease with resident #003 responsive behaviour. The Administrator and DOC both identified that resident #003's care plan should have been revised when there had been a change in their needs, and it had not been. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, and/or protocols, the policy and/or protocol were complied with.

In accordance with Ontario Regulation 79/10, section 49, the licensee was required to ensure that the falls prevention and management program must, at a minimum, provided for strategies to reduce or mitigate falls, including the monitoring of residents. Specifically, the license failed to comply with their policy titled “Resident Rights, Care and Services- Required Programs- Falls”, last revised May 7, 2019, which directed registered staff to complete a progress note in the resident’s chart after a resident had sustained a fall.

A CI report was submitted to the Director, related to resident #002, who had sustained a fall that resulted in a transfer to hospital. The CI report further indicated that the resident had sustained an injury, that required further intervention at the hospital.

Inspector #736 conducted a record review of resident #002’s progress notes, as well as the post fall assessments for the resident. The Inspector noted that on a specific date, there was an entry that had indicated the resident had sustained a fall; the Inspector was unable to locate a corresponding progress note in the resident’s chart.

In separate interviews with RPN #110 and RN #111, they both indicated to the Inspector that after a resident had sustained a fall, the registered staff were required to complete the assessment, as well as complete a progress note in the resident’s chart.

In separate interviews with both the Restorative Care Coordinator (RCC) and the DOC, they indicated that after a resident had fallen, the process in the home was that the registered staff would complete a post fall assessment in Point Click Care, and then complete a progress note in the resident’s chart. Together with the Inspector, both the RCC and DOC separately reviewed a report on a specified date, and indicated that it showed that resident #002 had sustained a fall. The RCC and the DOC were unable to locate a corresponding progress note in resident #002’s chart to indicate that the resident had sustained a fall on the specific date. Both the RCC and DOC indicated to the Inspector, that as there was no progress note, the staff did not comply with the home’s falls policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent care had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A CI report was submitted to the Director, related to an allegation of improper or incompetent care of resident #001. The CI report indicated that on date prior to the report being submitted, resident #001 was found in their bed with a specified item around the resident.

The Inspector noted that on the CI report, the home had indicated that the After Hours reporting line had been contacted. The Inspector reviewed the After Hours report, and noted that the After Hours reporting line had been contacted sometime later in the day, to indicate that the resident had been found early on the same day, with a specified item tied around a specific location of the resident's body.

A review of the licensee's policy, titled "Resident Rights, Care and Services-Abuse- Zero-Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019, indicated that the Administrator or Director of Care, or the Manager on Call, when notified of an allegation of abuse or neglect, would immediately notify the Ministry of Health and Long Term Care via the after hours pager if it was outside of normal business hours, or during business hours, notify the Ministry of Health and Long Term Care immediately by way of Critical Incident System (CIS) report.

In an interview with the Administrator, they indicated to the Inspector that they were made aware of an allegation of improper or incompetent care of resident #001 on the date that the After hours line had been notified. Together, the Inspector and Administrator reviewed the CI report, and the Administrator indicated that the allegation was not immediately reported to the Director and should have been. [s. 24. (1)]

Issued on this 7th day of August, 2020

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

Original report signed by the inspector.