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
Nov 10, 2021	2021_745690_0022	011914-21, 012153-21, 014474-21, 016342-21	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

TRACY MUCHMAKER (690)

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): October 26-29, 2021, and November 1-3, 2021.

The following intakes were inspected upon during this Critical Incident System inspection:

-One intake, related to improper/incompetent care of a resident;
-One intake, related to an allegation of resident to resident abuse; and
-Two intakes, related to falls with injury and a transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Regional Manager, Director of Care (DOC), Restorative Care Coordinator (RCC), Infection Prevention and Control Lead, Behavioural Supports Ontario Staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, Security Guards, 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 and resident to resident interactions, observed infection prevention and control practices, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

A resident was transferred to the hospital and was diagnosed with an identified injury.

A progress note, described a prior incident that occurred related to an identified diagnosis. There were no progress notes identified to indicate that the Physician had been made aware of the incident. The Director of Care (DOC), stated that the Physician should have been made aware of the incident and confirmed that there was no progress note or any notes in the doctor's book to indicate that they had been made aware.

The home's failure to ensure that staff and others collaborate with each other in the assessment of the resident, resulted in a minimal risk of harm to the resident.

Sources: A resident's progress notes, care plan and interviews with staff and the DOC. [s. 6. (4) (a)]

2. a) The licensee has failed to ensure that the Substitute Decision Maker (SDM), for two residents, had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A resident had an area of altered skin integrity and a treatment had been ordered by the Physician.

There was no progress note to identify that the resident’s SDM had been notified of the altered skin integrity, or the prescribed treatment. Registered staff and the DOC verified that the SDM had not been made aware of the altered skin integrity and the prescribed treatment, and that they should have been.

The home's failure to ensure that the resident's SDM had been provided the opportunity to participate fully in the plan of care related to altered skin integrity, presented a minimal risk of harm to the resident.

Sources: A resident's progress notes, health records, the home’s investigation notes, Interviews with staff and the DOC.

b) A resident was transferred to the hospital and was diagnosed with an identified injury.

A progress note, described a prior incident that occurred related to an identified diagnosis. There were no progress notes identified to indicate that the SDM had been made aware of the incident. The Director of Care (DOC), stated that the SDM should have been made aware of the incident.

The home's failure to ensure that the resident's SDM had been provided the opportunity to participate fully in the plan of care related to a change in health condition, presented a minimal risk of harm to the resident.

Sources: A resident's health records, progress notes, and Interviews with staff and the DOC. [s. 6. (5)]

3. The licensee has failed to ensure that a resident’s plan of care was revised related to

the management of responsive behaviours, when care needs changed.

A resident had a history of an identified responsive behaviour. Documents found in the resident's health chart from an external agency identified that recommendations were developed for staff to follow in response to the demonstrated responsive behaviour approximately three months prior to the inspection.

The resident's care plan did not include information related to the demonstrated responsive behaviour and recommendations for staff to follow until just prior to the inspection.

Personal Support Worker (PSW) and Registered staff stated that they would utilize the care plan and Kardex on Point Click Care (PCC) to find out what interventions were in place for the resident. The DOC verified that the interventions were only added to the care plan approximately three months after the recommendations were made, and that they should have been added at the time that the recommendations were put into place.

The home's failure to revise the care plan with interventions for the management of the resident's responsive behaviours, presented a minimal risk of harm to the resident.

Sources: The home's investigation notes, a resident's health records and care plan, interviews with staff and the DOC. [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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, that the SDM is provided with the opportunity to participate fully in the development of the plan of care and that the resident is re-assessed and the care plan revised when care needs change, to be implemented voluntarily.

WN #2: 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 the Falls Prevention and Management policies and procedures included in the required Falls Prevention Program were complied with, for a resident.

O. Reg. 79/10, s. 48 (1) 1, requires an organized program for Falls Prevention to reduce the incidence of falls and the risk of injury, and O. Reg. 79/10, s. 49 (1) requires that the program includes strategies to reduce or mitigate falls, including the monitoring of residents, and the implementation of restorative care approaches.

Specifically, staff did not comply with the home's policy and procedure "Falls Prevention and Management Program", dated May 7, 2019.

The home's Falls Prevention Policy indicated that the Falls Prevention Program would provide for strategies to reduce or mitigate falls, including the monitoring of residents, and the implementation of restorative care approaches. The policy further stated that all unwitnessed falls would result in a specified type of monitoring being initiated.

a) A resident had a fall and was transferred to the hospital and had a significant change in their health status. The resident had sustained subsequent falls and was discussed at a meeting due to the continued falls. A progress note documented related to the meeting, indicated that the falls were related to a specified Activity of Daily Living (ADL), and that an intervention was required to be implemented. There was no task on Point of Care or any information on the care plan to indicate that the intervention had been implemented.

PSW and Registered staff verified that the intervention had not been implemented. The Restorative Care Coordinator (RCC) and the DOC both verified that the intervention was

to be implemented in response to the resident's continued falls as a strategy to try to prevent falls and that it had not yet been implemented.

The home's failure to implement the identified falls prevention intervention for the resident, presented an minimal risk of harm to the resident.

Sources: A resident's post fall assessments, progress notes, the home's Falls Prevention and Management Policy, interviews with the DOC and other staff.

b) The same resident, was found lying on the floor on two identified dates, and staff implemented a specified type of monitoring after both falls as they were unwitnessed falls. The documentation for the monitoring for each of the falls, indicated that the monitoring was not completed on three occasions.

Two registered staff members stated that if a resident had an unwitnessed fall, staff were to initiate the specified type of monitoring according to the schedule identified on the monitoring form. Both Registered staff verified that the monitoring for both of the falls were not fully completed and that they should have been.

The home's failure to complete the monitoring on the resident, presented a minimal risk of harm to the resident.

Sources: A resident's progress notes, health records, the home's Falls Prevention and Management Policy, interviews with Registered staff and the DOC. [s. 8. (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 Falls Prevention and Management policies and procedures are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

A resident was noted to have an area of altered skin integrity and had an initial skin assessment on an identified date. A review of skin and wound assessments, and progress notes on PCC, identified a progress note documented on two occasions indicated that the resident refused to allow staff to assess the area of altered skin integrity. There were no other skin assessments completed over the five week period, until an assessment was completed and identified that the area of altered skin integrity had healed.

An RN, and the DOC, further verified that there had not been weekly skin assessments completed and that there should have been.

The home's failure to ensure that a resident's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, presented a minimal risk of harm to the resident.

Sources: A resident's skin and wound assessments on PCC, and progress notes, interviews with staff and the DOC. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity is reassessed at least weekly by a member of the Registered nursing staff, to be implemented voluntarily.

WN #4: 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 strategies had been implemented to respond to a resident's demonstrated responsive behaviours.

A resident had a history of responsive behaviours towards other residents. An incident occurred where the resident had a demonstrated responsive behaviour towards another resident that caused an injury to the other resident. The resident was to have an intervention in place, at specified times. When the incident occurred, the identified intervention had not been implemented.

The resident's care plan indicated that an identified intervention was to be in place during specified times in response to the resident's demonstrated responsive behaviours

towards other residents. Staff were to ensure that the intervention was in place and functioning.

PSW and Registered staff confirmed that at the time of the incident the interventon had not been implemented and that it should have been. The DOC stated that it was the responsibility of staff to ensure that the intervention had been implemented at specified times, including when the incident occurred and that it had not been.

The home's failure to ensure that the resident's identified intervention was implemented, presented a minimal risk of harm to the residents.

Sources: A Critical Incident System (CIS) report, a resident’s progress notes and care plan, interviews with staff and the DOC. [s. 53. (4) (b)]

2. The same resident was observed by the Inspector during the inspection, at a specified time and the inspector observed that an identified intervention was not in place. A staff member advised the inspector that there were responsible to ensure that the intervention was in place at that time, to ensure the safety of the other residents and that it had not been in place at the time of the observation.

The resident’s care plan indicated that the resident was to have the intervention in place for a specified time period everyday. The DOC stated that the resident was to have had the intervention in place at the time of the observation.

The home's failure to ensure that the resident's identified intervention was implemented at the time of the observation, present a minimal risk of harm to the resident.

Sources: Observation of the resident, the resident’s care plan, interviews with staff, and the DOC. [s. 53. (4) (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 strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are implemented, to be implemented voluntarily.

Issued on this 16th day of November, 2021

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

Original report signed by the inspector.