Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: April 4, 2023	
Inspection Number: 2023-1325-0001	
Inspection Type: Critical Incident System	
Licensee: Huntsville Long Term Care Centre Inc.	
Long Term Care Home and City: Muskoka Landing, Huntsville	
Lead Inspector Shannon Russell (692)	**Inspector Digital Signature** Shannon K Russell Digitally signed by Shannon K Russell Date: 2023.04.06 09:30:29 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 20, 21, 22, 23, 24, 2023

The following intake(s) were inspected:

- One intake, related to improper medication management/administration, neglect of a resident;
- One intake, related to an incident of staff to resident abuse; and,
- One intake, related to an incident of resident-to-resident responsive behaviour, resulting in injury.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that when a resident was demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to the interventions were documented.

Rationale and Summary
A Registered Practical Nurse (RPN) heard a resident screaming. When they entered the room, they found another resident exhibiting a responsive behaviour, that resulted in injury to the resident who was screaming.

The following day the physician wrote an order, which indicated that Dementia Observation System (DOS) charting was to be implemented on the resident who had exhibited the responsive behaviour. A review of the DOS charting for the resident, identified that 77 per cent of the time, the documentation was not completed.

Direct care staff, the Director of Care (DOC) and the Administrator, all identified that when the DOS charting was implemented for a resident, the expectation was that it would be completed in its entirety.

There was moderate impact and risk to the resident when staff did not complete the DOS charting as required, in that the assessments lacked the information necessary to initiate appropriate interventions to mitigate responsive behaviours towards others.

Sources: CIS report; two resident's health care records; LTC home's policies titled, "LTC Responsive Behaviour Program", version 5, last revised October 27, 2022; internal investigation file; and interviews with direct care staff, the DOC and the Administrator. [692]

COMPLIANCE ORDER CO #001 Duty To Protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.
The Licensee has failed to comply with LTCHA, 2007, s. 19 (1).

The licensee shall:
1. Develop and implement a process to monitor when a resident is refusing medications or treatments, and the follow up taken in response to the refusals.

2. Maintain records of the monitoring, including the follow up that was completed, for at least one month post the compliance due date, to ensure sustainability.
3. Ensure all registered staff are trained on the process required for notifying a resident's Attending Physician when there is a change in the resident's condition.
4. Maintain a record of the training/re-training provided, including dates, times, attendees, trainers, and material taught.

Grounds
1. The licensee has failed to ensure that a resident was protected from abuse by a Personal Support Worker (PSW).

The Ontario Regulations (O. Reg.) 79/10, s. 2 (1), defines physical abuse as, "the use of physical force by anyone other than a resident that causes physical injury or pain".

Rationale and Summary
A PSW reported that they had witnessed another PSW providing care to a resident in rough manner, and that they were restricting the resident's movements. The resident was heard saying "did not want to" and "leave [them] alone"; however, the PSW continued to provide the care, in a rough manner.

The PSW indicated that the other PSW was using excessive force, more than necessary, when providing care to the resident. A RPN identified that when they had assessed the resident, that there had been an injury in the area where they were being restricted, and the resident indicated pain in that area.

The DOC and Administrator identified that the allegation of physical abuse towards the resident by a PSW was substantiated, and that the appropriate follow up was completed with the staff involved.

There was a moderate impact and moderate risk to the resident, as the resident had verbalized the incident had caused them to be upset, and resulted in an injury to them.

Sources: CIS report; a resident's health care records; internal investigation notes; the home's policy titled, "LTC Abuse-Zero-Tolerance policy for resident abuse and neglect", version 5, last revised May 7, 2022; and interviews with direct care staff, the DOC and the Administrator.

2. The licensee has failed to ensure that a resident was protected from neglect by staff.

O. Reg. 79/10, s. 5., indicates the definition of neglect means "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one

or more residents".

Rationale and Summary
A resident was prescribed a medication, as a preventative measure, for an identified diagnosis. The resident refused the medication for a period of seven days, the physician was made aware on the eighth day; no changes to the resident's plan of care were made. The resident continued to refuse the medication for an additional five days.

When the resident had not received the medication, the resident sustained a significant change in their condition, which required an admission to the hospital for an extended period of time. When the resident returned to the home, their condition continued to decline, which resulted in returning to the hospital, where they subsequently passed away.

The DOC and Administrator indicated that the resident had been neglected, as they had not been provided with the care and treatment that they had required for the identified diagnosis. They both identified that by the resident refusing the medication there should have been prompt follow up with alternative measures put in place.

There was a high impact and a high risk to the resident for the inaction of staff, which resulted in the delay in them receiving the care that they required.

Sources: CIS report; a resident's health care records; the homes internal investigation notes; staff personnel files; the home's policy titled, "LTC Abuse-Zero-Tolerance policy for resident abuse and neglect", version 5, last revised May 7, 2022; and interviews with direct care staff, the DOC, and the Administrator.

This order must be complied with by May 5, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.