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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## 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 |
|---|---|---|---|
| Mar 24, 2021 | 2021_772691_0006 | 024349-20, 024558-20, 000669-21, 001225-21, 001602-21 | Critical Incident System |

### Licensee/Titulaire de permis

The District of the Municipality of Muskoka
98 Pine Street Bracebridge ON P1L 1N5

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

The Pines
98 Pine Street Bracebridge ON P1L 1N5

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

JENNIFER NICHOLLS (691), 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): February 22-March 03, 2021.**

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

**-Four intakes submitted to the Director regarding allegations of staff to resident abuse.**

**-One intake submitted to the Director regarding an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.**

**A Follow up Inspection (2021_772691_0005) and Complaint Inspection (2021_772691_0007) were conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Infection Prevention and Control Lead, Environmental Services Team Members, Personal Support Worker (PSWs), Resident Care Aides (RCAs), and residents.**

**The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care to residents, observed staff to resident interactions, observed Infection Prevention and Control practices, reviewed relevant health care records, internal investigation notes, staff education records, as well as relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Dignity, Choice and Privacy**
**Falls Prevention**
**Infection Prevention and Control**
**Prevention of Abuse, Neglect and Retaliation**

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

**5 WN(s)**
**4 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD. |

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a staff member respected a resident's dignity and rights when providing care.

A resident reported that they felt they did not have their rights respected by a staff member and the staff member neglected to provide the care the resident had requested in a timely manner. A review of the home's investigation notes and a resident interview identified that the resident was upset, and felt their rights were not respected.

Sources: Internal investigation notes, interviews with the resident, and the DOC. [690] [s. 3. (1) 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 ensuring that every resident is treated with courtesy, respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.***

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**WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**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 resident received assistance with identified ADLs as per the resident's plan of care.

A resident's plan of care identified that the resident was to receive certain care. In an interview with the staff member, they acknowledged that the resident did not receive the care identified in their care plan on one particular shift.

Sources: Resident's care plan and task flow reports; Interviews with the DOC, and other staff [s. 6. (7)]

2. The licensee has failed to ensure that the resident's specified interventions was documented.

A review of POC documentation identified that there was missing documentation for several occasions related to the resident's specified intervention.

Sources: Resident's POC documentation; interviews with the DOC and other staff. [s. 6. (9) 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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan; and the provision of care set out in the plan of care is documented, to be implemented voluntarily.***

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**WN #3: 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 an incident of alleged staff neglect towards a resident was immediately reported to the Director.

The home submitted a Critical Incident System (CIS) report for an incident of alleged staff to resident abuse, neglect or improper care. The incident was not reported to the Director until the day after the incident had occurred. The Director of Care (DOC) indicated that this allegation should have been reported immediately to the Director.

Sources: CIS report, investigation notes; the home's Zero Tolerance of Abuse and Neglect policy, last updated June 2020; interviews and statements the DOC, and other staff. [s. 24. (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 ensuring that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, has occurred or may occur shall immediately report the suspicion and the information upon which it is based on the Director, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program, specifically relating to the use of IPAC signage.

The Inspectors noted that one resident had (PPE) supplies outside their door with no signage posted indicating specific additional precautions required. As per the home's policy, they should have posted appropriate additional precautions (IPAC) signage to ensure proper use of (PPE) to protect staff and other residents in the home from the risk of disease transmission.

Sources: Inspector #691 observations; the licensee's policy titled "Droplet Precautions", last reviewed October 2020; COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007; Record reviews including diagnosis, care plan and flow sheets for resident #008; Interview with the Director of Care and other staff. [s. 229. (4)]

***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 ensuring that all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident was protected from abuse.

Physical abuse is defined within the Ontario Regulations 79/10 of the LTCHA, 2007, as "the use of physical force by anyone other than a resident that causes physical injury or pain". Emotional abuse is defined as “any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident”.

A resident was noted to have an identified injury.The resident reported that a staff member had caused the identified injury when providing care.

In an interview with the resident, they indicated to the Inspector that a staff member had caused them to have the injury while providing care to them.The resident stated that it made them feel hesitant to ask that staff member for assistance.

The above finding is further evidence to support the order issued on November 9, 2020, during a follow up Inspection 2020_853692_0007 to be complied December 14, 2020.

Sources: The home’s zero tolerance of abuse and neglect policy, last updated June 2020; internal investigation notes, interviews with the resident, and the DOC. [s. 19. (1)]

2. The licensee has failed to ensure that the resident was protected from neglect.

Neglect is defined within the Ontario Regulation 79/10, as 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.

A CIS report was submitted to the Director for an incident in which a staff member discovered that an identified object had been placed in the resident's room that caused the resident to not be able to call for assistance.The staff member immediately removed the device and reported the observation to a Registered Nurse.

During a review of the home's investigation notes, the Inspector identified statements that the staff member acknowledged that they had placed the device in the resident's room so the resident could not request assistance.

The above finding is further evidence to support the order issued on November 9, 2020, during a follow up Inspection 2020_853692_0007 to be complied December 14, 2020.

Sources: The home’s zero tolerance of abuse and neglect policy; last updated June 2020, the home’s internal investigation notes; CIS report; interviews with the DOC, and other staff members. [s. 19. (1)]

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**Issued on this 7th day of April, 2021**

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

**Original report signed by the inspector.**