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
Oct 21, 2021	2021_745690_0020	010613-21, 010644-21, 010840-21, 014778-21	Complaint

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

TRACY MUCHMAKER (690), CHAD CAMPS (609)

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): September 27-29, October 1, and October 4-8, 2021.

The following intakes were inspected upon during this Complaint inspection:

-One intake, related to a complaint related to care concerns;

-One intake, related to essential caregiver restrictions; and

-One intake, related to an allegation of staff to resident abuse.

A Critical Incident System (CI) intake related to the same concerns (an allegation of staff to resident abuse) was completed during this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Commissioner of Health Services, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Covid-19 Screener, Personal Support Workers (PSWs), Housekeepers 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, reviewed relevant health care records, internal investigation notes, complaint logs, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

5 WN(s)
5 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents related to COVID-19 active screening for of all persons entering the home.

COVID-19 Directive #3 stated that homes must ensure that all individuals were actively screened for symptoms and exposure history for COVID-19 before they were allowed to enter the home. The Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes, stated that the home should include at minimum the set of questions listed on the tool.

Upon entering the home on the first and second day of the inspection, the COVID-19 Screener did not ask the Inspectors all the questions on the home’s screening tool, and did not obtain contact information . The Inspector’s were unable to locate a posted copy of the screening tool and identifying symptoms.

Upon review of the home’s screening tool that was in use at the time of the inspection, the tool did not include the minimum required questions.

The Screener, admitted to the Inspector that they were supposed to ask all the questions on the home’s screening tool, but they generally did not ask them all. The Screener and the Director of Care both verified that the home was not collecting contact information of all visitors and the home’s screening tool did not include all the questions on the Ministry of Health COVID-19 Screening Tool. The DOC further verified that the screening tool had not been posted in the home.

The home’s failure to ensure that all person's entering the home were screened for COVID-19 as per COVID-19 Directive #3, presented a minimal risk to the residents.

Sources: Observations of the screening process, Covid-19 Directive #3, dated July 16, 2021, the home’s COVID-19 screening tools, interviews with the Screener and the Director of Care (DOC). [s. 5.]

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 a safe and secure home for the residents and that all persons entering the home are screened for Covid-19 as per Covid-19 Directive #3., to be implemented voluntarily.

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 care was provided as per the plan of care for a resident.

A complaint was submitted to the Director related to the care of a resident, specifically that staff were not following the plan of care related to specified treatments.

The resident’s plan of care indicated that the resident was to have a specified treatment in place and staff were to check the specified treatment at identified time frames.

The home’s complaint logs and documentation, identified that on multiple occasions, the resident did not receive the treatment as per the plan of care.

Personal Support Worker (PSW) staff, Registered staff, and the Administrator verified that there were times when the resident did not receive the treatment as per the plan of

care. The Administrator verified that staff were to provide care as per the plan of care.

The home's failure to ensure that care was provided to the resident as per the plan of care presented an actual risk of harm to the resident.

Sources: A resident's plan of care, the home’s complaint investigation notes, Interviews with the Administrator and other staff. [s. 6. (7)]

2. A resident's electronic medication administration record (eMar) documentation identified that Registered Staff were to check that a specified treatment was in place at specified intervals. Point of Care (POC) documentation identified that PSW staff were to also check the specified treatment as specified intervals.

The emar documentation identified that there was no documentation of the specified checks on 13 occasions during one month, and nine occasions during the following month.

The resident's eMar, identified that the resident was to receive another specified treatment at specified times.There was no documentation indicating that the treatment was applied on six occasions during a one month period and, and on five occasions in the following month. The eMar further identified that staff were to apply another specified treatment to a specified area at specified times. There was no documentation for application of the treatment on five occasions in a one month period and on four occasions in the following month.

An Registered staff, verified the missing documentation and indicated that there should not be any missing documentation on the emar. The Registered staff indicated that if PSW staff applied the treatment, then Registered staff were to document as applied by PSW. The Registered staff further stated that Registered staff were to document all the treatments on the eMar. The Administrator stated that staff were to document all treatments on the eMar and that there should not be any missing documentation.

The home's failure to document the specified treatments posed a minimal risk of harm to the resident.

Sources: A resident's emar and POC documentation, Interviews with Administrator 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 to ensure that care is provided as specified in the plan of care, and documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that had been received concerning the care of a resident or the operation of the home was forwarded to the Director.

The home's compliant logs and investigation notes, identified multiple complaints submitted to the home through email related to the care of a resident during the months over a four month period. The Ministry of Long Term Care reporting system identified that there were no written complaints related to the resident during that time period.

The home's policy titled "Complaints and Customer Service", indicated that written complaints included written notification in any format, including emails, and that where required by provincial authorities, the home would forward a copy of the written complaint and response to the appropriate regulatory body.

The Administrator verified that not all of the email complaints had been forwarded to the Director during that period and that they should have been.

The home's failure to forward all written complaints to the Director presented a minimal risk of harm to the resident.

Sources: The home's complaint investigation notes and complaint logs, the home's Complaints and Customer Service Policy, Interview with the Administrator. [s. 22. (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 any written complaint received concerning the care of a resident or the operation of the home is forwarded to the Director, to be implemented voluntarily.

WN #4: 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 was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, 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, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

The home’s complaint records identified multiple complaints related to care concerns of a resident. There were multiple complaints submitted over several months, and the Inspector could not find any information related to those complaints on the home’s complaint log. The home’s policy titled “Complaints and Customer Service”, indicated that each contact with the complainant should be recorded on the log.

The Administrator verified that the home was in the process of addressing the complaints, there were no records of the multiple complaints submitted or the home’s communication with the complainant during that time period, on the home’s complaint logs and that there should have been.

The home's failure to keep a documented record of all verbal and written complaints presented a minimal risk of harm to the resident.

Sources: The home’s complaint logs, and investigation notes, the home’s policy titled “Complaints and Customer Service-RC-09-01-04”, last revised June 2021, Interview with the Administrator. [s. 101. (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 a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint is received, 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, the final resolution, if any, every date on which any response is provided to the complainant and a description of the response, and any response made by the complainant., to be implemented voluntarily.

WN #5: 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 the Infection Prevention and Control (IPAC) program, was implemented, specifically to ensure there was signage posted on or near the entrance door of affected residents that indicated the resident was on additional precautions and the home's hand hygiene program.

In accordance with Public Health Ontario, Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, homes were required to have signage specific to the type(s) of additional precautions posted. A sign that listed the required precautions was to be posted at the entrance to the resident's room or bed space.

Three residents, electronic care plans, the identified that the staff were directed to follow contact precautions when providing care to the three residents. During observations of the resident's rooms, the Inspector did not locate any signage on the door to the resident rooms or in the bed space to indicate the required additional precautions and there was

no Personal Protective Equipment (PPE) available by the door or in the resident’s rooms.

PSW staff, the DOC and the Administrator, verified that there should have been signage posted on the three residents doors or bed space to notify staff of the additional precautions that were in place, and that there should have been the required PPE readily accessible to staff.

The home’s failure to ensure that signage was posted on the door to the room or the bed space, and to have the required PPE readily accessible presented an minimal risk of harm to the residents.

Sources: Inspector #690's observations, three resident's care plans, Interviews with the DOC and other staff, and Public Health Ontario, Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012. [s. 229. (4)]

2. The Inspectors observed meal service on three separate occasions, and observed residents being brought into the dining room and removed from the dining room and did not observe residents being provided with assistance to perform hand hygiene.

PSW staff verified to the inspector that they were aware that staff were to assist and encourage residents with hand hygiene before and after meals; however that it was not always happening. The DOC verified that staff were to provide assistance and encouragement to residents to perform hand hygiene before and after meal service.

The home’s failure to ensure that residents were encouraged and assisted to perform hand hygiene before and after meals presented a minimal risk of harm to the residents.

Sources: Observations on two separate days, interviews with residents, staff and the DOC. [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 to ensure that the Infection Prevention and Control Program is implemented, to be implemented voluntarily.

Issued on this 22nd day of October, 2021

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

Original report signed by the inspector.