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

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Original Public Report

Report Issue Date September 6, 2022
Inspection Number 2022_1575_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The District of the Municipality of Muskoka

Long-Term Care Home and City
The Pines, Bracebridge

Lead Inspector
Shannon Russell #692

Additional Inspector(s)
Sylvie Burns #627, Miko Hawken #724

Inspector Digital Signature
Shannon K Russell
Digitally signed by Shannon K Russell
Date: 2022.09.06 15:43:03 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 22-26, 2022

The following intake(s) were inspected:

- One intake, Follow up related to Compliance Order (CO) #001 from report #2022_1575_0001, O. Reg. 79/10, s. 131 (2), administration of medications;
- One intake, related to resident-to-resident responsive behaviours;
- Two intakes, for complaints submitted related to the management of a resident with responsive behaviours and discharging of the resident; and,
- Three intakes, related to allegations of staff to resident abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 131 (2)	2022_1575_0001	CO #001	#692

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

- Infection Prevention and Control (IPAC)

- Medication Management
- Prevention of Abuse and Neglect
- Responsive Behaviours

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable. There were *findings of non-compliance*.

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 19 (1) and FLTCA, 2021, s. 24 (1).

1. Non-compliance with: LTCHA, 2007, s. 19 (1)

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

Rationale and Summary
Neglect is defined within the Ontario Regulations (O. Reg) 79/10, of the Long Term-Care Homes Act (LTCHA), 2007, 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 resident had activated their call bell, which rang for one hour and 20 minutes. The resident pressed their call bell 76 times prior to the call bell being answered by the Personal Support Worker (PSW).

The Director of Care (DOC) acknowledged that the wait time for the resident to have their call bell answered was unacceptable; the call bells were to be answered immediately or as soon as possible by any staff member available. The Administrator stated that their investigation substantiated that the PSW had not responded to the call bell when they had heard it.

The resident was very upset by the wait time to have their call bell answered. There was moderate impact and risk to the resident when there was a delay in them receiving the care that they required.

Sources: Interviews with a PSW, DOC, Administrator and other staff members; health record review for a resident; Critical Incident System (CIS) report; home's investigation notes; call bell report; home's policy titled, "Zero Tolerance of Resident Abuse and Neglect program", #RC-02-01-01, last reviewed January 2022, and home's policy titled, "Nurse Call System, #RC-08-01-01, last reviewed January 2022. [627]

2. Non-compliance with: LTCHA, 2007, s. 19 (1)

The licensee has failed to ensure that a resident was protected from neglect from a PSW.

Rationale and Summary
At shift change, a PSW told the oncoming PSW that they had not completed care on a resident. The resident had gone for 11 and half hours with no care provided to them.

The DOC and both Assistant Directors of Care (ADOCs), received an email from a PSW regarding the alleged neglect of the resident. In the email the PSW had confirmed the incident of neglect, as they had witnessed the incident.

The DOC indicated that this was neglect of the resident by the PSW, and this posed a moderate risk to the resident by not providing care for over 11 hours.

Sources: CIS report; a resident's health care records; "Zero Tolerance of Resident Abuse and Neglect", #RC-02-01-01, last revised January 2022; homes internal investigation notes; interviews with RPNs, and the DOC. [724]

3. Non-compliance with: LTCHA, 2007, s. 19 (1)

The licensee has failed to ensure that a resident was protected from abuse and neglect by a PSW.

Rationale and Summary
Two PSWs had walked past a resident's room and heard them yelling that they needed assistance with a specific task. One of the PSWs replied to the resident in an inappropriate manner and shut the room door; they had not intervened to assist the resident.

The home substantiated this was verbal abuse and neglect.

This was a moderate impact and risk to the resident by verbally abusing the resident and by the PSW not providing care as per the request of the resident.

Sources: Interviews with PSW's, the DOC, Administrator; record review; home's investigation notes for the CIS report; home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program, #RC-02-01-01, last reviewed January 2022. [627]

4. Non-compliance with: FLTCA, 2021, s. 24 (1)

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

Rationale and Summary
Two staff members reported that they observed a resident exhibiting inappropriate responsive behaviours towards another resident. The staff members reported that the resident had

entered the other resident's room and that they had removed a specified intervention that had been in place.

Although the resident showed no distress after the incident, a moderate risk remains as the resident had demonstrated inappropriate responsive behaviours and had demonstrated the ability to circumvent interventions in place.

Sources: Interviews with PSW's, and DOC; record review; CIS report and investigation notes; the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program", #RC-02-01-01, last reviewed January 2022.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 24 (1)

The licensee has failed to ensure that anyone who had reasonable grounds to suspect abuse or unlawful conduct by a staff member that resulted in risk of harm to a resident, immediately reported the suspicion to the Director.

Rationale and Summary
The DOC and ADOC's received an email from a PSW, which contained an allegation of neglect towards a resident by an identified PSW.

The home's internal investigation identified that the PSW, who originally witnessed the neglect of the resident, had not reported the incident to the home's management until 19 days after the incident had occurred.

The DOC reported the alleged incident to the Director more than 20 hours after receiving the information, and that it should have been reported immediately upon becoming aware of the allegation.

Sources: CIS report; a resident's health care records; "Zero Tolerance of Resident Abuse and Neglect", #RC-02-01-01, last revised January 2022; homes internal investigation notes; Interviews with RPNs, and the DOC. [724]