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
Aug 25, 2020	2020_615759_0016	002130-20, 010050-20, 010611-20, 011065-20	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

KEARA CRONIN (759)

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): July 20-24, 2020. Additional off-site inspection activities were completed on August 11-12, 2020.

The following intakes were inspected during this Critical Incident System (CIS) Inspection:

- One intake related to an allegation of staff to resident abuse;
- One intake related to an incident of resident to resident abuse; and,
- Two intakes related to falls of a resident that resulted in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Cares (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, reviewed the home's internal investigation notes, staff education records and reviewed licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
3 VPC(s)
2 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. 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 resident #003, #004, #005, and #006 were protected from abuse by anyone.

A CIS Report was submitted to the Director on a specified date relating to incidents of alleged staff-to-resident abuse that occurred on a specified shift. The report outlined incidents in which PSW #113 allegedly abused resident #003, #004, #005, and #006. It further stated that the DOC received a call the following day from RPN #112, to report these concerns to them.

O. Reg. 79/10 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain" and emotional abuse 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".

The policy for the home's Zero Tolerance of Resident Abuse and Neglect Program, last reviewed January 31, 2020, indicated that "all resident's have the right to dignity, respect, and freedom from abuse and neglect. The organization has a Zero Tolerance policy for resident abuse and neglect".

A) The Inspector reviewed the home's investigation notes relating to the CIS report and identified a document from a specified date of a conversation between PSW #104 and the DOC.

i. In relation to resident #003, the Inspector identified that PSW #104 indicated to the DOC that PSW #113 applied force to resident #003 during care, and resident #003 responded with a responsive behaviour. PSW #104 asked PSW #113 to stop and leave.

During an interview with the Inspector, PSW #104 indicated that they requested assistance from PSW #113 to provide care to resident #003. Further, PSW #104 indicated that PSW #113 came in and applied force to resident #003.

ii. In relation to resident #004, the Inspector identified that PSW #104 reported to the DOC that PSW #113 pushed on an an identified area of the resident's body and moved resident #004 over with force. PSW #104 also reported that PSW #113 stated that "I know I'm rough with [resident #004], but I don't like [them]".

During an interview with the Inspector, PSW #104 further described the incident that

occurred. They stated that resident #004 mouthed to them "don't let [them] in, [they] hurt me".

Upon review of resident #004's progress notes, the Inspector noted a progress note for a referral that was written on a specified date by the DOC. The progress note indicated that there was an incident that occurred on a specified shift and resident's agitation had escalated since that time.

iii. In relation to resident #005, the Inspector identified that PSW #104 reported to the DOC that PSW #113 moved resident #005 "too hard" and caused an injury.

During an interview with the Inspector, PSW #104 indicated that PSW #113 was provoking and flicking resident #005's hair. They also indicated that PSW #113 moved resident #005 so fast that they caused an injury.

Upon review of resident #005's progress notes, the Inspector identified a progress note written by RPN #112 that stated when resident #005 was moved, they attempted to strike the PSW, missed, and caused an injury.

B) During an interview with the Inspector, PSW #104 indicated that while they were providing care to resident #006, resident #006 was displaying a responsive behaviour. They further indicated that PSW #113 was pushing/provoking resident #006, resulting in the resident's responsive behaviour to worsen.

The Inspector reviewed the investigation notes for the incident and identified a document written by PSW #104, which indicated that at the beginning of the shift, they went to provide care to resident #006 and PSW #113 assisted them. PSW #104 further wrote that PSW #113 was pushing forcefully at the resident. The Inspector identified another document on a specified date, of a conversation between PSW #104 and the DOC. The document identified that PSW #104 reported to the DOC that PSW #113 was physically pushing resident #006 with force.

During an interview with the Inspector, PSW #105 indicated that they did not witness the incident, although they observed resident #006 following the incident. They indicated that resident #006 was heightened and they could not get them to calm down.

Furthermore, the Inspector identified a letter written by the DOC in the investigation notes that was addressed to PSW #113 that indicated that "based on an investigation into a

report I received about you, I have concluded that you engaged in serious misconduct on [a specified date]".

During separate interviews with the Inspector, the Administrator and DOC both indicated that all incidents of alleged abuse to resident #003, #004, #005, and #006, were substantiated. [s. 19.]

2. The Inspector further reviewed home's Zero Tolerance of Resident Abuse and Neglect Program, last reviewed January 31, 2020, which indicated that "all employees, volunteers, agency staff, private duty caregivers,contracted service providers, residents, and families, are required to immediately report any suspected or known incident of abuse or neglect to the Director of the MOHLTC and the Administrator or designate in charge of the home".

A) The Inspector reviewed the home's investigation notes relating to the incidents and identified a document from a specified date that was written by PSW #104. The document further described the incidents relating to PSW #113's behaviour on a specified shift:
- At a specified time, when PSW #104 and PSW #113 were providing care to resident #006, PSW #113 was poking the resident, messing their hair, and causing escalated behaviours. PSW #104 retrieved assistance from PSW #105 to assist with the transfer;
- At a specified time, PSW #113 assisted PSW #104 to transfer resident #004. PSW #113 applied force to an area resident #004's body and PSW #113 stated to PSW #104 "I know I am rough [with them], I don't like [them];
- At a specified time, PSW #113 moved resident #005 and caused a injury; and
- At a specified time, resident #003 was resistive to care and PSW #104 called PSW #113 for assistance. PSW #104 applied force to resident #003, which resulted in responsive behaviour from resident #003 to PSW #113.

The Inspector identified in the same document that these incidents were "reported to [RPN #112] later at the end of shift".

Further non-compliance was also identified under WN #2.

B) The Inspector reviewed the home's investigation notes relating to the incidents and identified a document written by the DOC on a specified date at a specified time, "[RPN #112] left writer a voicemail to contact [them] regarding concerns from [their shift on a specified date]. Writer called [RPN #112] back at time above and [RPN #112] stated that

it was a terrible shift".

Further non-compliance was also identified under WN #4. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A CIS Report was submitted to the Director on a specified date, relating to incidents of alleged staff-to-resident abuse that occurred on a specified day, between PSW #113 and residents #003, #004, #005 and #006. Please refer to WN #1 for details.

The policy for the home's Zero Tolerance of Resident Abuse and Neglect Program, last reviewed January 31, 2020, indicated that "all employees, volunteers, agency staff, private duty caregivers,contracted service providers, residents, and families, are required to immediately report any suspected or known incident of abuse or neglect to the Director of the MOHLTC and the Administrator or designate in charge of the home".

During an interview with the Inspector, the Adminsitrator indicated that all staff received annual training on the home's zero tolerance of abuse and neglect policy and were expected to report any suspected abuse immediately to the charge nurse or anyone on the leadership team. The Administrator also indicated to the Inspector that they could call the Ministry of Long-Term Care to report any incidents of alleged abuse as well.

The Inspector reviewed the home's investigation notes relating to the incidents and identified a document from a specified date that was written by PSW #104. The document further described the incidents relating to PSW #113's behaviour on a specified shift:
- At a specified time, when PSW #104 and PSW #113 were providing care to resident #006, PSW #113 was poking the resident, messing their hair, and causing escalated behaviours. PSW #104 retrieved assistance from PSW #105 to assist with the transfer;
- At a specified time, PSW #113 assisted PSW #104 to transfer resident #004. PSW #113 applied force to an area resident #004's body and PSW #113 stated to PSW #104 "I know I am rough [with them], I don't like [them];
- At a specified time, PSW #113 moved resident #005 and caused a injury; and
- At a specified time, resident #003 was resistive to care and PSW #104 called PSW #113 for assistance. PSW #104 applied force to resident #003, which resulted in responsive behaviour from resident #003 to PSW #113.

The Inspector identified in the same document that these incidents were "reported to [RPN #112] later at the end of shift".

The Inspector reviewed a document in the home's investigation notes that was written by RPN #112 on a specified date, that stated "this was reported to writer [at specified time]" and "writer called [the DOC] first thing the next morning from home".

The Inspector interviewed PSW #104, who confirmed they witnessed the four incidents of alleged staff-to-resident abuse that occurred throughout a specified shift on a specified date. They indicated that they reported these incidents that on that date to RPN #112.

The Inspector interviewed RPN #112, who indicated that they spoke with PSW #104 at a specified time and that because of the late nature and since PSW #113 would have gone home, RPN #112 reported the incidents the next day to the DOC.

The Inspector interviewed the DOC and they indicated that through their investigation it was identified that at the end of the shift, RPN #112 could tell something was upsetting PSW #104, so RPN #112 spoke to PSW #104. The DOC further indicated that RPN #112 contacted them the next day and indicated that they needed to talk to PSW #104 regarding the incidents that occurred on the specified shift. The DOC contacted PSW #104 and PSW #104 let them know what occurred over the course of the shift.

During separate interviews with the Inspector, the DOC and the Administrator confirmed that these incidents should have been reported immediately to their supervisor. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (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 the care set out in the plan of care was provided to resident #007 as specified in the plan.

A CIS report was submitted to the Director as a result of a fall, in which resident #007 experienced a significant change to their health status. The CIS report indicated that resident #007 was heard by staff calling out for help. Upon assessment of resident #007, there was an injury noted to a specified area.

The Inspector reviewed resident #007's current care plan on a specified date, relating to falls. The Inspector identified a specified falls intervention.

During an interview with the Inspector, PSW #108 indicated that resident #007 required a specified intervention that was used to prevent falls.

During the inspection, the Inspector observed resident #007 in their room. The Inspector observed the specified intervention, however, the intervention was not in place.

Upon review of the home's policy titled "Falls Prevention and Management Program", last updated December 2019, the Inspector noted that it indicated to "implement any strategies and interventions as outlined on the resident's plan of care".

The Inspector interviewed PSW #115, they indicated that they just provided care to resident #007 and must have not reapplied the intervention. When asked by the Inspector if it was to be applied to resident #007, they responded yes. [s. 6. (7)]

2. The licensee has failed to ensure that resident #007's plan of care was reviewed and revised when the resident's care needs changed.

A CIS report was submitted to the Director as a result of a fall, in which resident #007 experienced a significant change to their health status. The CIS report indicated that resident #007 was heard by staff calling out for help. Upon assessment of resident #007, there was an injury noted to a specified area.

Upon review of the home's policy titled "Care Planning" last reviewed March 2013, the Inspector noted that "ongoing, Registered Staff and other members of the interdisciplinary team are responsible for updating the residents' plan of care to ensure it remains current and reflective of the care needs of the resident at any given point in time".

The Inspector reviewed resident #007's progress notes and identified a progress note that indicated that resident #007 was found on the floor in a specified area calling out for help. It further indicated that the resident was transferred to the hospital for treatment.

During an interview with the Inspector, PSW #115 indicated that resident #007 had a fall "awhile back" and had a change to their mobility status.

During an interview with the Inspector, the DOC explained resident #007's change in condition relating to their ambulation status and use of mobility aids.

The Inspector reviewed resident #007's care plan that was completed on a specified date, and reviewed the focus relating to falls. The Inspector noted the falls interventions

indicated that resident #007 utilized a mobility device.

The Inspector reviewed resident #007's care plan revisions, and noted that the falls intervention relating to the use of the mobility device was updated to a different mobility device on a later date by the DOC.

The Inspector interviewed ADOC #102 and reviewed the care plan relating to the use of a mobility device that was updated on a specified date. The ADOC confirmed that if the fall was in a specified month, it would not have been accurate, and that the care plan should have been updated sooner to reflect their care needs. [s. 6. (10) (b)]

3. The licensee has failed to ensure that the plan of care was reviewed and revised when resident #008's care needs changed.

A CIS report was submitted to the Director as a result of a fall that occurred which caused a significant change to resident #008's health care status. The CIS report indicated that resident #008 was found on the floor on a specified date. On a later day, resident #008 was diagnosed with an injury.

The Inspector reviewed resident #008's progress notes and identified a progress note written on a specified date, that indicated that resident #008 experienced a fall. The Inspector identified a progress note written on a later date, that indicated that resident #008 experienced an injury and used an intervention for transfers.

During separate interviews with the Inspector, PSW, #109 and PSW #116 indicated that resident #008 required a specified level of assistance for transfers.

The Inspector reviewed resident #008's MDS assessment that was completed on a specified date, which indicated that resident #008 required a specified level of assistance for transfers.

The Inspector reviewed resident #008's care plan that was current on a specified date, and reviewed the focus relating to transfers and identified an intervention that indicated they required a different level of assistance for transfers. The Inspector noted that this intervention was last revised prior to the fall that occurred on a specified date.

During an interview, the Inspector reviewed resident #008's care plan with PSW #109. The Inspector reviewed with PSW #109 that the care plan indicated that resident #008

required a level of assistance for transfers. PSW #109 confirmed that was not correct and that it should have said they required a different level of assistance.They further confirmed that this was last revised prior to the fall.

During an interview, the Inspector reviewed resident #008's care plan with RN #109 who also confirmed that the care plan had not been updated. [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 the resident is reassessed and the plan of care reviewed and revised at least every six months or at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: 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 the person who had reasonable grounds to suspect abuse of resident #003, #004, #005, and #006, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS Report was submitted to the Director on a specified date relating to incidents of alleged staff-to-resident abuse that occurred on a specified shift. Please see WN #1 for details.

The policy for the home's Zero Tolerance of Resident Abuse and Neglect Program, last reviewed January 31, 2020, indicated that "all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families, are required to immediately report any suspected or known incident of abuse or neglect to the Director of the MOHLTC and the Administrator or designate in charge of the home".

During separate interviews with the Inspector, RPN #107 and PSW #108 both indicated that they report any form of suspected abuse immediately to their supervisor.

The Inspector reviewed the home’s investigation notes relating to the incidents and identified a document written by the DOC on a specified date at a specified time, “[RPN #112] left writer a voicemail to contact [them] regarding concerns from [a specified shift]". Writer called [RPN #112] back at time above and [RPN #112] stated that it was a terrible shift”.

The Inspector interviewed RPN #112, they indicated that they spoke with PSW #104 at a specified time and that because of the late nature and since PSW #113 would have gone home, RPN #112 reported the incidents the next day to the DOC.

The Inspector interviewed the DOC and they indicated that RPN #112 contacted them the next day and indicated that they needed to talk to PSW #104 regarding the incidents that occurred on the specified shift. The DOC contacted PSW #104 and PSW #104 let them know what occurred over the course of the shift.

During separate interviews with the Inspector, the Administrator and the DOC both indicated that they would have expected these incidents to be reported immediately to the Director. [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 to ensure that any person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that result in harm or risk of harm immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (8) Every licensee shall ensure that every use of a physical device to restrain a resident pursuant to the common law duty referred to in section 36 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (8).
2. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (8).
3. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (8).
4. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (8).
5. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (8).
6. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain #001 pursuant to the common law duty referred to in section 36 of the Act was documented with the following: the person who made the order, what device was ordered, and any instructions relating to the order; the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's

response; every release of the device and all repositioning; the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

A CIS report was submitted to the Director as a result of an altercation that occurred between resident #001 and #002. The Inspector reviewed the CIS report, it described the incident that occurred and as a result resident #001 was restraint by a device by staff to ensure safety of all.

During separate interviews with the Inspector, RPN #106 indicated that the device used was considered a restraint and RPN #117 indicated that it was used as a last resort. RPN #120 and the DOC indicated that the progress notes were the only place used to document the use of the device.

During an interview, RPN #120 indicated that the process of using the device as a restraint was unclear and there were a lot of questions following the incident regarding the use of it.

Upon review of the home’s policy titled “Least Restraints” last updated December 2019, the Inspector noted “In cases of Emergency Restraint, the following must include: a full description of the events leading up to the need for the physical restraint; name and designation of person ordering the restraint; time restraint was applied and the frequency of monitoring checks; any special care provided during the restraint use; notification of the resident's SDM; when reassessment is to occur; and completion of an incident report”.

The Inspector reviewed resident #001’s progress notes during a specified time frame, and identified that the device was used as an emergency restraint an identified number of times as a response to a responsive behaviour:

A) The Inspector reviewed resident #001’s progress notes relating to the use of the device as an emergency restraint for an identified number of incidents that occurred on specified dates and was unable to identify the following: the person who made the order, what device was ordered, and any instructions relating to the order; the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident’s response; and every release of the device and all repositioning.

During an interview with RPN #119, the Inspector reviewed resident #001's progress notes relating to the use of the identified device on one of the dates. RPN #119 indicated that at that point it was used as a restraint because the resident was threat to staff and other residents. They further indicated that the decision to apply the restraint was made by themselves and the PSWs, and that the resident was monitored.

The Inspector interviewed RPN #106 relating the use of the identified device on the other date, they indicated that they assisted resident #001 into the device. They also indicated that RPN #120 monitored resident #001 for the duration.

During an interview, the Inspector reviewed resident #001’s progress notes that were written on the two dates, with ADOC #102 and ADOC #103. The Inspector also reviewed the requirements in the regulations relating to the documentation of restraining a resident under the common law duty. ADOC #102 confirmed that the documentation on one of the dates did not include all of the requirements outlined in the Regulations that was noted by the Inspector, and ADOC #103 confirmed that the documentation another date did not include all of the requirements outlined in the Regulations that was noted by the Inspector.

B) The Inspector reviewed resident #001’s progress notes relating to the use of the device as an emergency restraint for the incidents that occurred on identified additional dates and was unable to identify the following: the person who made the order, what device was ordered, and any instructions relating to the order; the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident’s response; every release of the device and all repositioning; and the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

During an interview, the Inspector reviewed resident #001’s progress notes that were written on the additional dates, with ADOC #102 and ADOC #103. The Inspector also reviewed the requirements in the regulations relating to the documentation of restraining a resident under the common law duty. ADOC #103 confirmed that the documentation on the identified dates did not include all of the requirements outlined in the Regulations that was noted by the Inspector.

During an interview with the DOC, the Inspector reviewed the identified occurrences in which the home utilized the device as an emergency restraint for resident #001. The DOC indicated that the documentation from all of the incidents did not include

documentation to support the assessment and re-assessment of the resident while they were restrained. They also indicated to the Inspector that there was no clear documentation to support whether resident #001 was monitored on an identified number of the dates while using the device. [s. 110. (8)]

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 ensure that every use of a physical device to restrain a resident pursuant to the common law duty referred to in section 36 of the Act, is documented and shall ensure that the following are documented: 1. The circumstances precipitating the application of the physical device. 2. The person who made the order, what device was ordered, and any instructions relating to the order. 3. The person who applied the device and the time of application. 4. All assessment, reassessment and monitoring, including the resident's response. 5. Every release of the device and all repositioning. 6. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.

Issued on this 27th day of August, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KEARA CRONIN (759)
Inspection No. / No de l'inspection :	2020_615759_0016
Log No. / No de registre :	002130-20, 010050-20, 010611-20, 011065-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 25, 2020
Licensee / Titulaire de permis :	The District of the Municipality of Muskoka 98 Pine Street, BRACEBRIDGE, ON, P1L-1N5
LTC Home / Foyer de SLD :	The Pines 98 Pine Street, BRACEBRIDGE, ON, P1L-1N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kim Landry

To The District of the Municipality of Muskoka, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the Long Term Care Homes Act, 2007.

Specifically, the licensee must ensure that residents of the home are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #003, #004, #005, and #006 were protected from abuse by anyone.

A CIS Report was submitted to the Director on a specified date relating to incidents of alleged staff-to-resident abuse that occurred on a specified shift. The report outlined incidents in which PSW #113 allegedly abused resident #003, #004, #005, and #006. It further stated that the DOC received a call the following day from RPN #112, to report these concerns to them.

O. Reg. 79/10 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain" and emotional abuse 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".

The policy for the home's Zero Tolerance of Resident Abuse and Neglect Program, last reviewed January 31, 2020, indicated that "all resident's have the right to dignity, respect, and freedom from abuse and neglect. The organization

has a Zero Tolerance policy for resident abuse and neglect".

A) The Inspector reviewed the home's investigation notes relating to the CIS report and identified a document from a specified date of a conversation between PSW #104 and the DOC.

i. In relation to resident #003, the Inspector identified that PSW #104 indicated to the DOC that PSW #113 applied force to resident #003 during care, and resident #003 responded with a responsive behaviour. PSW #104 asked PSW #113 to stop and leave.

During an interview with the Inspector, PSW #104 indicated that they requested assistance from PSW #113 to provide care to resident #003. Further, PSW #104 indicated that PSW #113 came in and applied force to resident #003.

ii. In relation to resident #004, the Inspector identified that PSW #104 reported to the DOC that PSW #113 pushed on an an identified area of the resident's body and moved resident #004 over with force. PSW #104 also reported that PSW #113 stated that "I know I'm rough with [resident #004], but I don't like [them]".

During an interview with the Inspector, PSW #104 further described the incident that occurred. They stated that resident #004 mouthed to them "don't let [them] in, [they] hurt me".

Upon review of resident #004's progress notes, the Inspector noted a progress note for a referral that was written on a specified date by the DOC. The progress note indicated that there was an incident that occurred on a specified shift and resident's agitation had escalated since that time.

iii. In relation to resident #005, the Inspector identified that PSW #104 reported to the DOC that PSW #113 moved resident #005 "too hard" and caused an injury.

During an interview with the Inspector, PSW #104 indicated that PSW #113 was provoking and flicking resident #005's hair. They also indicated that PSW #113 moved resident #005 so fast that they caused an injury.

Upon review of resident #005's progress notes, the Inspector identified a progress note written by RPN #112 that stated when resident #005 was moved, they attempted to strike the PSW, missed, and caused an injury.

B) During an interview with the Inspector, PSW #104 indicated that while they were providing care to resident #006, resident #006 was displaying a responsive behaviour. They further indicated that PSW #113 was pushing/provoking resident #006, resulting in the resident's responsive behaviour to worsen.

The Inspector reviewed the investigation notes for the incident and identified a document written by PSW #104, which indicated that at the beginning of the shift, they went to provide care to resident #006 and PSW #113 assisted them. PSW #104 further wrote that PSW #113 was pushing forcefully at the resident. The Inspector identified another document on a specified date, of a conversation between PSW #104 and the DOC. The document identified that PSW #104 reported to the DOC that PSW #113 was physically pushing resident #006 with force.

During an interview with the Inspector, PSW #105 indicated that they did not witness the incident, although they observed resident #006 following the incident. They indicated that resident #006 was heightened and they could not get them to calm down.

Furthermore, the Inspector identified a letter written by the DOC in the investigation notes that was addressed to PSW #113 that indicated that "based on an investigation into a report I received about you, I have concluded that you engaged in serious misconduct on [a specified date]".

During separate interviews with the Inspector, the Administrator and DOC both indicated that all incidents of alleged abuse to resident #003, #004, #005, and #006, were substantiated. [s. 19.]

2. The Inspector further reviewed home's Zero Tolerance of Resident Abuse and Neglect Program, last reviewed January 31, 2020, which indicated that "all employees, volunteers, agency staff, private duty caregivers,contracted service providers, residents, and families, are required to immediately report any suspected or known incident of abuse or neglect to the Director of the MOHLTC

and the Administrator or designate in charge of the home".

A) The Inspector reviewed the home's investigation notes relating to the incidents and identified a document from a specified date that was written by PSW #104. The document further described the incidents relating to PSW #113's behaviour on a specified shift:
- At a specified time, when PSW #104 and PSW #113 were providing care to resident #006, PSW #113 was poking the resident, messing their hair, and causing escalated behaviours. PSW #104 retrieved assistance from PSW #105 to assist with the transfer;
- At a specified time, PSW #113 assisted PSW #104 to transfer resident #004. PSW #113 applied force to an area resident #004's body and PSW #113 stated to PSW #104 "I know I am rough [with them], I don't like [them];
- At a specified time, PSW #113 moved resident #005 and caused a injury; and
- At a specified time, resident #003 was resistive to care and PSW #104 called PSW #113 for assistance. PSW #104 applied force to resident #003, which resulted in responsive behaviour from resident #003 to PSW #113.

The Inspector identified in the same document that these incidents were "reported to [RPN #112] later at the end of shift".

Further non-compliance was also identified under WN #2.

B) The Inspector reviewed the home's investigation notes relating to the incidents and identified a document written by the DOC on a specified date at a specified time, "[RPN #112] left writer a voicemail to contact [them] regarding concerns from [their shift on a specified date]. Writer called [RPN #112] back at time above and [RPN #112] stated that it was a terrible shift".

Further non-compliance was also identified under WN #4.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 3 as it related to four out of four residents reviewed. The home had a level 2 history of previous non-compliance to a different section. (759)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 18, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the Long Term Care Homes Act, 2007.

Specifically, the licensee must:

1) Re-educate Personal Support Worker #104 and Registered Practical Nurse #112 on the home's policy for Zero Tolerance of Resident Abuse and Neglect, focusing on the reporting requirements for incidents of suspected resident abuse.

Grounds / Motifs :

1. The licensee has failed to ensure that the the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A CIS Report was submitted to the Director on a specified date, relating to incidents of alleged staff-to-resident abuse that occurred on a specified day, between PSW #113 and residents #003, #004, #005 and #006. Please refer to WN #1 for details.

The policy for the home's Zero Tolerance of Resident Abuse and Neglect Program, last reviewed January 31, 2020, indicated that "all employees, volunteers, agency staff, private duty caregivers,contracted service providers, residents, and families, are required to immediately report any suspected or known incident of abuse or neglect to the Director of the MOHLTC and the Administrator or designate in charge of the home".

During an interview with the Inspector, the Administrator indicated that all staff received annual training on the home's zero tolerance of abuse and neglect policy and were expected to report any suspected abuse immediately to the charge nurse or anyone on the leadership team. The Administrator also indicated to the Inspector that they could call the Ministry of Long-Term Care to report any incidents of alleged abuse as well.

The Inspector reviewed the home's investigation notes relating to the incidents and identified a document from a specified date that was written by PSW #104. The document further described the incidents relating to PSW #113's behaviour on a specified shift:
- At a specified time, when PSW #104 and PSW #113 were providing care to resident #006, PSW #113 was poking the resident, messing their hair, and causing escalated behaviours. PSW #104 retrieved assistance from PSW #105 to assist with the transfer;
- At a specified time, PSW #113 assisted PSW #104 to transfer resident #004. PSW #113 applied force to an area resident #004's body and PSW #113 stated to PSW #104 "I know I am rough [with them], I don't like [them];
- At a specified time, PSW #113 moved resident #005 and caused a injury; and
- At a specified time, resident #003 was resistive to care and PSW #104 called PSW #113 for assistance. PSW #104 applied force to resident #003, which resulted in responsive behaviour from resident #003 to PSW #113.

The Inspector identified in the same document that these incidents were "reported to [RPN #112] later at the end of shift".

The Inspector reviewed a document in the home's investigation notes that was written by RPN #112 on a specified date, that stated "this was reported to writer [at specified time]" and "writer called [the DOC] first thing the next morning from home".

The Inspector interviewed PSW #104, who confirmed they witnessed the four incidents of alleged staff-to-resident abuse that occurred throughout a specified shift on a specified date. They indicated that they reported these incidents that on that date to RPN #112.

The Inspector interviewed RPN #112, who indicated that they spoke with PSW #104 at a specified time and that because of the late nature and since PSW #113 would have gone home, RPN #112 reported the incidents the next day to the DOC.

The Inspector interviewed the DOC and they indicated that through their investigation it was identified that at the end of the shift, RPN #112 could tell something was upsetting PSW #104, so RPN #112 spoke to PSW #104. The DOC further indicated that RPN #112 contacted them the next day and indicated that they needed to talk to PSW #104 regarding the incidents that occurred on the specified shift. The DOC contacted PSW #104 and PSW #104 let them know what occurred over the course of the shift.

During separate interviews with the Inspector, the DOC and the Administrator confirmed that these incidents should have been reported immediately to their supervisor.

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 3 as it related to four out of four residents reviewed. The home had a level 3 history of previous non-compliance related to the same subsection of the Act that included:
- Voluntary plan of correction (VPC) issued September 6, 2019 (2019_746692_0020). (759)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 18, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 25th day of August, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Keara Cronin

Service Area Office /
Bureau régional de services : Sudbury Service Area Office