Ontario

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

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
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Original Public Report

Report Issue Date: October 23, 2023.

Inspection Number: 2023-1305-0003

Inspection Type:
Complaint
Critical Incident

Licensee: 2063412 Ontario Limited as General Partner of 2063412 Investment LP

Long Term Care Home and City: Muskoka Shores Community, Gravenhurst

Lead Inspector	**Inspector Digital Signature**
Amanda Belanger (736)	Amanda Lee Claire Belanger Digitally signed by Amanda Lee Claire Belanger Date: 2023.11.01 13:09:10 -04'00'

Additional Inspector(s)
Shannon Russell (692)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25-29, 2023.

The following intake(s) were inspected:

- two intakes related to unexpected deaths;
- one intake related to allegations of resident to resident abuse;
- one intake related to a complaint about resident care; and,
- one intake related to a hypoglycemic incident.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Interventions to Promote Wound Healing

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee has failed to ensure that two residents received treatment and interventions to promote healing and prevent infection related to impaired skin integrity.

Summary and Rationale
Two residents had wound care ordered, however, there was no documentation to indicate that wound care had been provided as directed.

The ADOC reviewed the resident's charts and confirmed that there was no indication that wound care had been completed as per the residents' plan of care on the above dates. The ADOC further confirmed that the wound care should have been provided and documented.

Sources: Residents care plans, physicians orders, e-treatment administration records (eTARs), and progress notes; interviews with the ADOC, and other relevant staff.

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WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

Summary and Rationale
The resident was noted to have a change in status, however, the Physician was not notified of the resident’s change in condition.

The Personal Support Worker (PSW) recalled informing the Registered Practical Nurse (RPN) that the resident was experiencing a change in condition. There was no related RPN documented assessment.

The Physician indicated that nursing staff should have completed an assessment and notified the on call doctor immediately based on the outcome of the assessments.

The ADOC indicated that based on the documentation available, the RPN neglected the resident by failing to assess the resident in a timely manner and failing to notify the RN of the resident's sudden change in condition.

Sources: The resident's progress notes, and assessments; and interviews with physician, Personal Support Worker (PSW), ADOC

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WRITTEN NOTIFICATION: Weekly Wound Assessments

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that three residents who had wounds, had their wounds assessed at least weekly.

Summary and Grounds
Three residents had identified skin and wound concerns. There was no documentation to indicate that the wounds had been assessed on a weekly basis.

The Skin and Wound Care Lead indicated that wounds were not being assessed weekly for the three residents that were reviewed, and should have been.

Sources: Residents assessments, care plans, and progress notes; licensee policy titled "Skin and Wound Care Management Protocol", VII-G-10.90, last revised August 2023; and, interview with Skin and Wound Care Lead, and other staff.

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WRITTEN NOTIFICATION: Reports to the Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5)

The licensee has failed to ensure that when there was an unexpected death of the resident, the report was submitted to the Director as requested.

Summary and Rationale
The After Hours Reporting line was contacted to report the unexpected death of the resident.

The home was contacted twice after and requested to submit the written report to the Director. The report was not received until four days after the incident was first reported to the Director.

The Executive Director (ED) indicated that the report should have been submitted the next business day.

Sources: CI report and after hours report and, interview with the ED.

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