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
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: February 21, 2024.

Inspection Number: 2024-1305-0001

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: 2024.03.11 11:09:49 -04'00'

Additional Inspector(s)
Amy Geauvreau (642)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15-19, 2024.
The inspection occurred offsite on the following date(s): January 22- 26, and 29, 2024.

The following intake(s) were inspected:

- Three intakes related to allegations of resident to resident abuse;
- one intake related to a complaint regarding improper care;
- one intake related to an allegation of staff to resident neglect;
- two intakes related to complaints regarding resident safety;
- one intake related to an outbreak; and,
- one intake related to the fall of a resident that resulted in injury.

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

Continence Care
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
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,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when it was not longer effective related to fall prevention measures.

Rationale and Summary
A resident sustained multiple falls over a period of time. Progress notes indicated that interventions had been trialed, but not added to the plan of care. The plan of

care had an intervention added, however, the resident continued to sustain a number of falls, some that resulted in injury, before the plan of care was revised again.

The Interim Director of Care (DOC) indicated that resident's plan of care should have been reviewed and revised, as it was ineffective in fall prevention management.

There was risk of harm to the resident, as the plan of care was not reviewed and revised to determine if further and different fall prevention interventions would have been effective in fall management.

Sources: The resident's progress notes, assessments and care plan; Critical Incident (CI) report; licensee policy titled "Fall Prevention and Management"; and interview with the Interim DOC.

[736]

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)
Duty to protect
s. 24 (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.

The licensee has failed to ensure that residents were protected from abuse by another resident.

Rationale and Summary

There was an altercation between two residents, which resulted in harm to one resident. Prior to the incident, there had been previous concerns between the two residents, and despite interventions in place, staff indicated that the interventions were not effective in managing the situation.

The Interim DOC confirmed that the home did not adequately protect one resident from abuse by another resident.

There was harm to a resident as a result of the incident.

Sources: Two residents progress notes and care plans; CI report; internal reports; licensee policy titled "Abuse Prevention"; interview with a resident, Personal Support Worker (PSW), Registered Practical Nurse (RPN), Interim DOC, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Continence Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable.

The licensee had failed to ensure that a resident had sufficient continence care product changes to remain clean, dry and comfortable.

Rationale and Summary
A resident required continence care, however, there was a delay in the care being provided to the resident.

Associate Director of Care (ADOC) indicated through investigation it was determined that care had been delayed, which resulted in staff having to provide additional care to the resident.

There had been minimal impact to the resident's health, safety, and quality of life at the time of the incident.

Sources: CI report; the complainant email; a resident's documentation; interviews with a PSW, and ADOC, and other staff. [642]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible.

The licensee has failed to ensure that two residents had their triggers for responsive behaviours identified in their plans of care.

Rationale and Summary
Two residents were known to display responsive behaviours, and had known triggers, however, neither residents' plan of care identified the known triggers for

staff to reference.

The Interim DOC confirmed that the two residents' plans of care should have identified the known triggers related to responsive behaviours.

There was risk to residents as a result of triggers related to responsive behaviours not being identified in the plan of care.

Sources: Two residents' progress notes, and care plan; interviews with a RPN, Interim DOC, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Infection Control and Prevention

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that residents were assisted with hand hygiene prior to meal service.

Rationale and Summary
The Inspector noted that residents were not being offered or assisted with hand hygiene prior to meal service. It was also noted that there were wipes on the tables for residents, however, the wipes did not contain any alcohol content, as required.

A PSW indicated that if residents brought themselves to the dining room, they were not assisted with hand hygiene.

The Interim IPAC Lead indicated that all residents were to be assisted with hand hygiene prior to meal service.

There was risk to residents at the time of non compliance as the home was in an outbreak.

Sources: Inspector's observations; licensee policy titled "Hand Hygiene Policy"; interviews with a PSW, Interim IPAC Lead, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Complaint Record

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)
Dealing with complaints
s. 108 (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;
(b) the date the complaint was received;
(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;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and

(f) any response made in turn by the complainant.
1. The licensee has failed to ensure that a written record was kept of complaints received by the home, and the actions taken.

Rationale and Summary
There were two concerns brought forward related to two separate resident concerns.

The Inspector reviewed the internal complaints, and there was no record of the complaint, or the actions the home had taken to resolve the complaint.

The Executive Director confirmed that there was no written record of the complaint received by the home.

There was low impact to the resident as a result of the home not keeping a written record of the complaint received.

Sources: Two residents progress notes, and assessments; CI report; licensee policy titled "Complaints Management"; and, interview with the Executive Director and other relevant staff.

[736]

2. The licensee had failed to ensure that there was a documented record of the final resolution to a complaint for a resident.

Rationale and Summary
A concern was brought forward to the home; the complainant identified they have concerns about a resident and specific health issues, and felt as though he home

had not followed up on the concerns.

Progress notes identified the complaint and some actions taken by the home, however, there was no further specific information documented of what the response of the complainant was or any final resolution.

The ADOC stated that they spoke to the complainant frequently after the concern, however there was no documentation of what was communicated.

The Executive Director stated that it was not clear what formal follow-up had been completed, since there was no complaint form completed.

There had been minimal impact to the resident's health, safety, and quality of life at the time of the incident.

Sources: Complaints Management Program; a resident's progress notes, care plan and assessments; interviews with the complainant, ADOC, DOC, Executive Director, and other staff. [642]

WRITTEN NOTIFICATION: Reporting to the Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease

as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that when an outbreak was declared in the home, the Director was immediately made aware.

Rationale and Summary
An outbreak was declared by Public Health in the home, however, the Critical Incident was not submitted until the next day.

Both the Interim IPAC Lead, and Interim DOC acknowledged that the outbreak was not immediately reported to the Director and should have been.

There was low impact to the residents as a result of the outbreak not being immediately reported to the Director.

Sources: CI report; and interview with Interim IPAC Lead, and Interim DOC.

[736]

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
Telephone: (800) 663-6965