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: September 13, 2024
Inspection Number: 2024-1305-0004
Inspection Type: Complaint Critical Incident Follow up
Licensee: 2063412 Ontario Limited as General Partner of 2063412 Investment LP
Long Term Care Home and City: Muskoka Shores Community, Gravenhurst

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 22-25, 2024

The following intake(s) were inspected:

- Two intakes which were related to incidents involving a resident that resulted in an injury;
- Three intakes which were related to a fall of a resident resulting in a transfer to the hospital;
- One intake which was a complaint related to falls prevention;
- One intake which was a follow up to a compliance order for O. Reg. 246/22, s. 55 (2) (b) (ii), and;
- One intake which was related to an allegation of physical abuse of a resident.

Previously Issued Compliance Order(s)

Ministry of Long-Term Care
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The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1305-0002 related to O. Reg. 246/22, s. 55 (2) (b) (ii)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

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 (11) (b)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee has failed to ensure that the effectiveness of the interventions for assisting a resident with their personal care needs were assessed and different approaches considered in the revision of the plan of care.

Rationale and Summary
The resident's care plan outlined specific interventions for staff to use to assist with daily care related to a specific personal care need. A referral made to an external agency indicated that there was an increase in a specified responsive behaviour and that the interventions outlined in the care plan were no longer effective.

Staff members stated that the resident almost always displayed a specified responsive behaviours during a specified time. That when that happened, they would implement the interventions in the care plan and if that did not work, care was not provided.

There were no records identified to indicate that the team had met to strategize or that different approaches were taken when the interventions were reassessed for effectiveness and found to be ineffective.

The Director of Care (DOC) confirmed that staff members should have considered different approaches to assist the resident with their personal care needs when it was identified that the interventions included in the care plan were ineffective.

Failure to ensure that staff considered different approaches when they determined that the interventions in place to assist a resident with their personal care needs were ineffective, put the resident at ongoing risk of not receiving the assistance required with their personal care needs.

Sources: Observations of a resident; CI report, a resident's health record, and the

licensee's policy titled, "Responsive Behaviours Management"; and interviews with the DOC and other staff members.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that allegations of abuse of a resident that were reported to the home, were immediately investigated.

Rationale and Summary
Concerns about the manner in which staff members were providing care on a resident were documented by registered staff in the resident's progress notes. According to the notes, the nurse in charge, the manager on call, and the DOC were all made aware of the allegations on the same day.

A review of the home's investigation records revealed the investigation into the allegations began two days later.

The DOC confirmed that the investigation did not begin right away.

Failure to ensure that an investigation occurred immediately into the alleged abuse

of a resident by staff members had minimal impact on the resident.

Sources: CI and After-hours reports; a resident's progress notes, internal communications, the licensee's policy titled, "Prevention of Abuse and Neglect", and the home's internal investigation file; and interviews with a registered staff member and the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that allegations of abuse of a resident were immediately reported to the Director.

Rationale and Summary
The home submitted a CI report to the Director regarding staff to resident physical abuse, two days after the incident had occurred.

According to the progress notes for the resident, the allegations of abuse were reported immediately to the nurse in charge, the manager on call, and the DOC.

The DOC verified that the allegations of staff to resident physical abuse were reported late to the Director.

Failure to immediately report the allegations of abuse to the Director may have placed the resident at risk of experiencing a similar incident and, resulted in a delay in the investigation into the allegations

Sources: CI and After-hours reports, a resident's progress notes, email correspondence, the licensee's policy titled, "Prevention of Abuse and Neglect", and "Critical Incident Reporting"; and interviews with a registered staff member and the DOC.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (3) (b)
24-hour admission care plan
s. 27 (3) The licensee shall ensure that the care plan sets out,
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 246/22, s. 27 (3).

The licensee has failed to ensure that the 24-hour admission care plan provided clear directions to staff related to a resident's fall prevention interventions.

Rationale and summary
A resident had a fall shortly after admission. The resident's 24-hour admission care plan indicated that the resident was at risk of falling and included interventions for staff to implement to prevent falls or injuries from falls.

An RN stated that they had updated the care plan and added interventions related to the falls prevention; however, the information in the care plan was not added correctly and did not provide clear directions to staff. The ED agreed that the care plan did not provide clear direction to staff related to the falls prevention interventions that were in place.

There was risk of harm related to not having clear direction in the resident's care plan related to falls prevention interventions as the resident was at risk of falling.

Sources: A resident's progress notes and care plan; interviews with an RN, and the ED.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the falls prevention program related to implementing strategies for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the falls prevention and management program must, at a minimum, provide strategies to reduce or mitigate falls, including the monitoring of residents, and the

use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the home's policy titled "Falls prevention and Management, VII-G-30.10" which stated that staff were to complete a falls risk assessment on admission, and update the care plan with resident specific fall prevention interventions. The policy further stated that Personal Support Workers (PSW)s were to utilize the fall prevention interventions identified on the resident's plan of care.

Rationale and summary
a) A resident was found on the floor shortly after admission. The post fall assessment described that the falls prevention interventions that were included on the 24-hour admission care plan were not in place at the time of the fall.

The DOC stated that the resident's fall prevention interventions should have been in place at the time of the fall and did not know why they were not.

There was a moderate impact to the resident as a result of not implementing required falls prevention interventions as the resident sustained a fall with a subsequent injury.

Sources: A resident's care plan and progress notes; Policy titled "Falls Prevention and Management, VII-G-30.10, last revised 06/2024; interviews with Registered staff, DOC, Clinical Care Partner, and the ED.

b) A resident was admitted to the home and a type of monitoring tool was initiated upon admission. The resident was at risk of falling, and progress notes indicated that specified falls prevention interventions were required to be in place. The resident sustained a fall that resulted in an injury during a specified time period. A review of

the monitoring tool documentation identified that there was no documentation during the specified time period.

An RN and the DOC verified that the monitoring tool was to be fully completed by staff during the specified time period and according to the documentation on the monitoring tool, it was not fully completed.

There was a moderate risk to the resident related to not completing the monitoring tool as the resident sustained a fall and subsequent injury during the period of time that the monitoring tool was not completed.

Sources: A resident's progress notes and documentation of the monitoring tool; interviews with an RN, and the DOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)
Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee has failed to ensure that equipment, supplies, devices, and assistive aids were readily available related to falls prevention.

Rationale and summary
A resident's admission progress notes indicated that the resident was at risk of falling and required specified equipment for falls prevention. Progress notes

documented later on the same day, indicated that staff were provided with a different piece of equipment, and that a request had been submitted for the required equipment.

The resident sustained a fall with an injury prior to the required equipment being implemented.

The home's Falls Prevention and Management Policy stated that a falls prevention kit should be accessible to frontline team members at all times, and that the home was to ensure that team members were aware of the location of the falls prevention kit.

An RN stated that they did not have access to the required equipment for the resident that day, so they provided a different type of equipment instead. The DOC and ED stated that the Charge Nurse should have accessed the equipment after hours from a fall prevention kit and provided the correct equipment.

There was a moderate risk of not having the equipment readily available for falls prevention as the resident was at risk of falling.

Sources: A resident's admission progress notes; Policy titled "Falls Prevention and Management, VII-G-30.10, last revised 06/2024; interviews with PSW staff, Registered staff, the DOC and ED.

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that resident with altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A resident was found to have areas of altered skin integrity requiring weekly reassessment.

A review of the skin and wound evaluations completed over a set period of time, revealed that the areas with altered skin integrity were not reassessed weekly.

The DOC confirmed that the resident's areas of altered skin integrity were not reassessed weekly as they should have been.

Failure to reassess the resident's areas of altered skin integrity on a weekly basis increased the resident's risk of the areas worsening because the effectiveness of the treatments provided was not evaluated.

Sources: A resident's progress notes and skin and wound assessments, and the licensee's policy titled, "Skin and Wound Care Management Protocol" and interviews with a registered staff member and the DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (2)

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.

The licensee has failed to ensure that a documented record of every verbal and written complaint was kept in the home related to a resident's care concerns.

Rationale and summary

A resident's progress notes described how the resident's family members expressed concerns and were unhappy with the care provided to the resident on multiple occasions. The home's complaint logs did not contain any information related to the care concerns of the resident.

The DOC stated that they were aware of the concerns brought forward, however; they were unaware if there was any documentation related to the concerns in the home's complaint logs. The Clinical Care Partner and the ED verified that there was no information documented related to the care concerns and that there should have been.

There was a low risk related to the home not documenting the concerns related to the resident in the home's complaint log.

Sources: A resident's progress notes; the home's investigation notes; the home's complaint logs; interviews with Registered staff, DOC, Clinical Care Partner and the ED.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed within one business day of an incident that caused an injury to resident, for which the resident was taken to hospital and resulted in a significant change in their health condition.

Rationale and Summary
A resident was injured while in the home, was taken to hospital for further assessment, and returned to the home the same day with a significant change in their condition that required ongoing care.

The Director was informed of the critical incident five days later.

The DOC confirmed that the critical incident was reported late.

Failure to notify the Director within one business day of an incident causing an injury to a resident resulting in a significant change to their health condition presented no risk to the resident.

Sources: CI report, a resident's progress notes and home's investigation file; and an interview with the DOC.

COMPLIANCE ORDER CO #001 Plan of care

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Ensure that the identified staff members review a specific resident's care plan and kardex, for interventions to ensure safe snack service.
2) Create and implement a process to ensure that all staff who assist with snack service for the specified resident have access to information on the snack cart regarding any adaptive aids and supervision needed; and that staff members implement the measures identified.

Grounds

The licensee has failed to ensure that a resident received the care specified in their plan of care. Specifically, a resident was not provided with specific adaptive aids or provided with the correct level of assistance when handling a specific beverage.

Rationale and Summary
A resident's care plan required staff to provide the resident with a specified level of assistance, and specific adaptive aids when receiving a specific beverage.

The resident was observed in their room with the specific beverage with no staff present and not all the adaptive aids were in place.

Staff members stated that they did not review the resident's plan of care before serving the resident the beverage; that they were not aware that the resident required the specified level of assistance or the specific adaptive aids when handling the beverage due to a previous incident that occurred.

The DOC confirmed that the care plan was not being followed at the time of the observation; that the resident should have been provided with the correct level of assistance by staff, and had the specific adaptive aids in place when handling the specific beverage.

Failure to ensure that a resident was provided with adaptive aids and the level of assistance while handling a specific beverage, placed the resident at increased risk of harm.

Sources: Observations of a resident; a resident's care plan, menu service report, and the licensee's policy titled, "Snack Service"; and interviews with the Director of Dietary Services, the DOC, and other staff.

This order must be complied with by October 25, 2024

COMPLIANCE ORDER CO #002 Dining and snack service

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Review and revise the home's meal and snack service policies, as well as temperatures at point of service, to ensure that beverages for meal times and snack and beverage service, are served at safe and palatable temperatures. The policies and procedures must include the following:
- parameters for safe and palatable temperatures when serving hot beverages
- information on what temperatures provide resident safety, comfort, and beverage satisfaction, how to achieve comfortable and safe temperatures, and a process for implementing corrective action, if required, to ensure that hot beverages are served at a safe and palatable temperature

2) Develop and implement an auditing process to ensure that residents are being provided with safe and palatable fluids in accordance to the revised home's policies and procedures.
3) Ensure that the auditing process includes verifying the appropriate action has been taken when beverages are found to be outside of the identified levels outlined

in the home's policies and procedures.
4) The audits must be completed at least weekly for a minimum of four weeks, or longer if ongoing concerns are identified, following the issuance of this order. Ensure that audits include the dates, time, name, and signature of the staff member completing the audit as well as any corrective actions taken if issues are identified during the auditing process.

Grounds

The licensee has failed to ensure that fluids in the home were served at a temperature that was both safe and palatable to the residents.

Rationale and Summary

The home was asked to provide their policies regarding snack service and beverage temperatures at the point of service. The documents provided by the home contained no information about safe beverage temperatures or requirements for staff to take temperatures of hot beverages before serving them to residents during meals or snack service.

The Director of Dietary Services and other staff members acknowledged that there was no process in place at the home to ensure that the beverages served to residents were safe and palatable; that the temperatures of beverages were not monitored or recorded at point of service. The Director of Dietary Services stated that even though they knew they had no policy in place regarding the safe temperatures at which to serve beverages, the home had made no changes to their processes to prevent a similar incident with other residents in the home.

Failure to ensure that the home had a process in place to ensure that beverages in the home were served at a temperature that was both safe and palatable, had a significant impact on a resident who sustained an injury when a prepared beverage

spilled on them and, placed other residents in the home at risk of experiencing a similar situation.

Sources: CI report, a resident's electronic health record, the licensee's policies titled, "Food Temperatures- Point of Service, and "Snack Service", last revised, Journal of Food Service, Vol. 84, Issu. 8, 2019-A Review of Hot Beverage Temperatures: Satisfying Consumer Preference and Safety, and Best Practices for Nutrition, Food Service, and Dining in LTC Home, 2019; and interviews with the Food Services Supervisor, Director of Dietary Services, DOC, and other staff.

This order must be complied with by October 25, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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