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

Public Report

Report Issue Date: September 5, 2025
Inspection Number: 2025-1575-0006
Inspection Type: Complaint Critical Incident
Licensee: The District Municipality of Muskoka
Long Term Care Home and City: The Pines, Bracebridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 25-29, 2025

The following intake(s) were inspected:

- One intake, which was a complaint related to care concerns;
- Two intakes, which were a complaint and critical incident (CI) related to an incident involving a resident; and
- One intake, which was a CI related to a medication incident.

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

Resident Care and Support Services
Medication Management
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that when a resident's care needs changed, the plan of care was revised.

A resident had a change in their health status and, there was a change in the level of assistance they required. The care plan that was in place at the time of the inspection had not been revised to reflect the current care needs, until it was brought to the attention of the Assistant Director of Care (ADOC).

Sources: A resident 's care plan, and assessments; interviews with a Personal Support Worker (PSW), Registered Practical Nurse (RPN), and the ADOC.

Date Remedy Implemented: August 28, 2025

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff utilized safe transfer techniques for a resident.

A resident's care plan and assessments indicated that the resident required a specified level of assistance to perform an activity of daily living (ADL). After an incident occurred, it was identified that staff had been providing a different level of assistance to perform the ADL.

Sources: A resident's care plan, and assessments; the home's investigation notes; interviews with a PSW, and the Director of Care (DOC).

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 5.
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):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

The licensee has failed to ensure that the Director was notified no later than one business day following a medication incident involving a resident that resulted in a transfer to the hospital.

A Critical Incident (CI) was submitted for a medication incident involving a resident that resulted in a transfer to the hospital that occurred two days prior.

Sources: A CI report; a medication incident report; interviews with an RPN and the ADOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was administered to a resident unless the drug was prescribed for the resident.

An RPN administered medications to a resident in error that were not prescribed to

them.

Sources: A medication administration Incident report; a resident's electronic medication administration record (emar); interviews with an RPN, and the ADOC.