Ontario

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

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

**North District**
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

## Original Public Report

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| **Report Issue Date:** May 2, 2024 | |
| **Inspection Number:** 2024-1305-0002 | |
| **Inspection Type:**<br>Complaint<br>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**<br>Shannon Russell (692) | **Inspector Digital Signature** |
| **Additional Inspector(s)**<br>Jennifer Nicholls (691) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 18 to 22, and 27, 2024.

The following intake(s) were inspected:
- Two intakes, related to complaints submitted to the Director regarding concerns with resident care;
- One intake, related to a fall of a resident, resulting in injury; and,
- One intake, related to an allegation of improper/incompetent care of resident.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Palliative Care
Reporting and Complaints
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Falls Prevention

NC #001 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 program to provide a falls risk assessment 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.

Specifically, staff did not comply with the home's Falls Prevention policy that stated that staff were to ensure that a fall risk assessment was to be done on a quarterly basis.

**Rationale and Summary**
A resident sustained an unwitnessed fall, which resulted in an injury. The resident's health care records identified that the last fall risk assessment had been completed months previous, which had identified the resident as a fall risk.

The Interim Director of Care (IDOC) indicated that the falls risk assessment had not been completed as per the home's policy and should have been.

There was risk of harm to the resident by the staff not complying with fall risk assessment policy, as the resident's health status was not assessed, and could have put them at increased risk for falling.

**Sources:** The home's policies titled "Falls prevention & Management", last revised April 2023; a resident's health record including fall risk assessment; and Interviews with the IDOC and other staff. [691]

## WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.**
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a written response to the complainant was completed within 10 business days of receipt of a written complaint submitted regarding an allegation of improper care of a resident.

**Rationale and Summary**
A written complaint was submitted to the long-term care homes (LTCHs) IDOC, regarding an allegation that a resident had suffered harm due to improper clinical management of their condition.

The IDOC did not provide a written response to the complainant until several days after they had received the written complaint alleging improper resident care.

There was low risk to the resident when the home had not responded to the complainant within 10 business days.

**Sources:** Critical Incident System (CIS) report; a resident's health care records; the home's internal investigation notes; the home's policy titled, "Complaints Management Program", last revised December 2023; and interviews with the IDOC and the Interim Executive Director (ED). [692]

## COMPLIANCE ORDER CO #001 Skin and wound care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)**
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:
a) Review the home's Skin and Wound Program with all Registered Nurses (RNs) to ensure that there are immediate treatments and interventions implemented for residents exhibiting impaired skin integrity;
b) Develop and implement an auditing process, to be completed by a member of the management team, for residents who have impaired skin integrity, to ensure that treatments and interventions are implemented. The audit is to include, but not limited to the following parameters:
- notification to the Director of Care (DOC) and/or Skin and Wound Lead;
- notification to the resident's Physician and/or Nurse Practitioner;
- notification to the resident's substitute decision maker (SDM);
- notification to the Registered Dietician (RD) for nutritional review and Physiotherapy (PT) for reviewing the need for special surfaces;
-implementation of treatments and interventions, not limited to strategies to prevent further skin breakdown, including turning and repositioning;
-the resident's treatment orders are up to date and are being followed; and,
-the corrective action taken if any discrepancies are noted during the auditing process.
(c) The audits are to be completed weekly and continued for a minimum of four weeks post compliance due date for sustainability. The records of the audits must be maintained and provided to the Inspector when requested.

**Grounds**
The licensee has failed to ensure that residents received immediate skin and wound

treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

**Summary and Rationale**
(a) A resident had altered skin integrity to a specific area, which had deteriorated, resulting in a significant change in their status.

The resident's health care records indicated that they had developed an area of altered skin integrity. The skin and wound assessments identified the area was worsening, and infection was suspected. However, there was no documentation found indicating what actions had been taken in response to the deteriorated wound by the registered staff. A referral for the pressure ulcer had not been completed to the RD and the PT until the resident had a change in their status. As well, the point of care (POC) documentation indicated that direct care staff were not turning, repositioning, or offloading pressure until multiple days after the altered skin integrity developed. The resident's SDM and most responsible physician (MRP) were not made aware of the worsening area of altered skin integrity until the resident had a significant change in their status.

The IDOC indicated there had been a time delay in registered staff taking action to prevent further infection, therefore immediate treatment or intervention was not provided as required, which resulted in the resident having a significant change in their status.

There was a high impact to the resident, due to the delay in implementing immediate treatment and interventions, as the residents altered skin integrity deteriorated, which resulted in the resident's significant change in status.

**Sources:** a resident's health care records; the homes policy "Skin and Wound Care

Management Protocol", last revised August 2023; and interviews with the resident's SDM, direct care and registered staff, a physician, and the IDOC.

(b) A different resident had developed altered skin integrity to a specific area and was to be monitored and treatment completed at a specific interval, and as required. On a specified date the area was noted to be worsening when assessed, which required further medical treatment.

A RN identified that they had not been made aware of the resident's worsening altered skin integrity and when they assessed the area on the specified date, there was indications of an infection, which required further medical intervention.

The home's failure to ensure that immediate treatment and interventions to promote healing, and prevent infection, were implemented for the resident's worsening altered skin integrity, presented a moderate impact to the resident.

**Sources:** A resident's health care records; the homes policy "Skin and Wound Care Management Protocol", last revised August 2023; and interviews with registered staff, a physician, and the IDOC. [692]

**This order must be complied with by** June 14, 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.