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
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Original Public Report

Report Issue Date: June 20, 2024.

Inspection Number: 2024-1305-0003

Inspection Type:
Proactive Compliance Inspection

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**
Amy Geauvreau (642)	Amy Geauvreau Digitally signed by Amy Geauvreau Date: 2024.07.02 17:27:20 -04'00'

Additional Inspector(s)
Charlotte Scott (000695)
Tiffany Forde (741746)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):

May 6-10, 2024.

The following intake(s) were inspected:

- Intake: #00114940 - PCI Inspection.

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

Skin and Wound Prevention and Management

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

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: O. Reg. 246/22, s. 167 (1)
Continuous quality improvement designated lead
s. 167 (1) Every licensee of a long-term care home shall ensure that the home's continuous quality improvement initiative is co-ordinated by a designated lead.

The licensee has failed to ensure that home's continues quality improvement (CQI)

initiative is co-ordinated by a designated lead.

Rationale and Summary
During a meeting, with the Director of Care (DOC) and the Executive Director (ED), they identified that there was no specific CQI Lead for the home.

The ED confirmed, days later that they were officially the Lead for the CQI program. There was minimal risk to residents when the home identified there was no Lead for the CQI program.

Sources: Interviews with Director of Care (DOC), and the Executive Director (ED), and other staff. [642]

Date Remedy Implemented: May 10, 2024.

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the required information was posted in the home, specifically related to the zero tolerance for abuse and neglect of residents policy.

Rationale and Summary

On a specific day, it was observed that the home's policy to promote zero tolerance of abuse and neglect of residents, was not posted in the home. A discussion with the ED and the DOC confirmed that the policy was not posted as required.

Days later, the DOC informed the Inspector that the policy to promote zero tolerance of abuse and neglect of residents was then posted in the home. The Inspector observed that the policy had been posted on the main communication board in the home.

There was low risk to residents when the home failed to ensure the zero tolerance for abuse and neglect of residents policy was posted.

Sources: Observations completed; the home's policy titled Prevention of Abuse and Neglect of a Resident VII-G-10.00; and interviews with the ED and DOC. [000695]

Date Remedy Implemented: May 6, 2024.

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the information required to be posted in the home and communicated to residents, included the current version of the visitor

policy as required under section 267.

Rationale and Summary
On specific days, it was observed that the home's visitor policy was not posted in the home. A discussion with the ED and the DOC confirmed that the policy was not posted as required.

Days later, the DOC informed the Inspector that the visitor policy was then posted in the home. The Inspector observed that the policy had been added to the front entrance of the home.

There was low risk to residents when the home failed to ensure the visitor policy was posted.

Sources: Observations completed; and interviews with the ED and DOC. [000695]

Date Remedy Implemented: May 6, 2024.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian

who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to ensure the home's policy, "Food Temperatures – Point of Service", regarding food temperatures was complied with.

Summary and Rationale
Pursuant to Ontario Regulation (O. Reg.) 246/22 s. 11 (1) b, the licensee was required to develop and comply with policies and procedures relating to nutritional care, dietary services and hydration.

Inspector reviewed specific floor's temperature logs, for food at point of service. There were missing temperature recordings for food items served to residents at various mealtimes.

An interview with Food Service Worker's (FSWs) confirmed, food temperatures were to be conducted by a FSW and recorded prior to each meal service, as per the home's Food Temperatures - Point of Service policy. The home's Director of Dietary services confirmed the temperatures should have been recorded.

There was low risk to residents as a result of the home's lack of logging food temperatures on two floors.

Sources: Policy: Food Temperatures - Point of Service; review of temperature logs at point of service; interviews with Food Service Workers (FSWs) and the Director of Dietary services.
[741746]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 43 (5)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (4);
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part X.

The licensee has failed to ensure that the documentation for the yearly Resident and Family/Caregiver Experience Survey: which should include the results, and actions taken to improve the long-term care home, should be made available to Residents' Council and during an inspection when requested.

Rationale and Summary
The DOC and other staff identified that the last Resident and Family Survey was completed.

Interview with the Residents' Council president, identified that, they did not receive the documented results of the last Resident and Family Survey.

The DOC stated they were unclear of what was provided to the Residents' Council.

There was low risk to residents when the home identified the Resident and Family survey had been completed, however it was unclear if the Residents' Council was provided documentation of the results and actions completed from the survey.

Sources: Documents, titled, CX Surveys, Living Resident Survey; Interview with President of the Residents' Council, interview with DOC, and other staff. [642]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2)
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any.

The licensee had failed to ensure the continuous quality improvement (CQI) committee was composed of the required persons: ED, DOC, Medical Director, the designated Leads, registered dietitian, pharmacy service provider, or pharmacist, one staff nurse, one personal support worker (PSW), one member of the Residents' Council, and one member of the Family Council, if any.

Rationale and Summary
During an interview with the home's DOC, and the ED, the continuous quality CQI meeting minutes were requested to identify, what staff, and members of the CQI committee attended the home's last meeting.

A document was provided, by the DOC, titled, "Professional Advisory Committee, Census." After a review of the document, two program Leads of the home were identified, however, there was no other names of staff, or the required persons identified for the CQI committee.

There was minimal risk to residents when the home could not provide the CQI meeting minutes, to identify the committee members.

Sources: Document, titled, "Professional Advisory Committee, Census,"; interview's

with DOC, ED, and other staff. [642]

WRITTEN NOTIFICATION: Infection Prevention and Control Lead

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 23 (4)
Infection prevention and control program
s. 23 (4) Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program.

The licensee has failed to ensure that the home had an Infection Prevention and Control (IPAC) Lead whose primary responsibility was the home's IPAC program.

Ontario Regulation 246/22, s. 102 (15) indicates that every licensee of a long-term care home shall ensure that the IPAC Lead designated under that section works regularly in that position on site at the home for a specific amount of time per week, based on the licensed bed capacity of the home.

Rationale and Summary
Interview with the ED and the DOC revealed the home did not have an internal IPAC Lead.

The IPAC Partner confirmed that they, along with two others external to the home were supporting the IPAC program, which had some gaps in meeting the required hours.

There was low risk when the licensee failed to ensure that the home had an IPAC Lead whose primary responsibility was the home's IPAC program.

Sources: IPAC Lead Job Description, email's; interviews with IPAC Partner, the DOC, and other staff.
[000695]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 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 any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented. Specifically, the licensee has failed to ensure that point of care signage, indicating enhanced IPAC measures, was in place and followed within the IPAC program as per the IPAC Standard for Long-Term Care Homes issued April 2022, last revised September 2023, section 9.1 (e).

Rationale and Summary
Observations completed, revealed that multiple rooms on a specific floor, were

identified as having additional precautions via specific signage and available personal protective equipment (PPE) requirements.

Interviews with various staff, indicated that multiple rooms had the incorrect additional precaution signage.

The DOC and the IPAC Partner confirmed that the additional precaution signage on the specific floor did not provide clear direction to staff and was not aligned with the home's policies and procedures.

There was low risk to residents when the home failed to ensure the point of care signage, indicating enhanced IPAC control measures, was in place and reflected the type of precautions required.

Sources: Inspector observations; the home's policy titled Additional Precautions, IX-G-10.70; IPAC Standard for Long-Term Care Homes issued April 2022; and interviews with the IPAC Partner, the DOC, and other staff.
[000695]