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

Report Issue Date: June 22, 2023

Inspection Number: 2023-1325-0002

Inspection Type:
Complaint
Follow up

Licensee: Huntsville Long Term Care Centre Inc.

Long Term Care Home and City: Muskoka Landing, Huntsville

Lead Inspector	**Inspector Digital Signature**
Shannon Russell (692)	Shannon K Russell Digitally signed by Shannon K Russell Date: 2023.06.27 13:57:26 -04'00'

Additional Inspector(s)
Samantha Fabiilli (000701)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 23-26, 2023.

The following intake(s) were inspected:

- One intake, which was follow-up for compliance order (CO) #001 from inspection #2023_1325_0001, related to Long-Term Care Homes Act (LTCHA), 2007, s. 19 (1), duty to protect residents; and,
- One Intake, which was related to a complaint that was submitted to the Director related to resident falls management and care concerns.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1325-0001 related to LTCHA, 2007 S.O. 2007, c.8, s. 19 (1) inspected by Shannon Russell (692)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

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 (1) (c)

The licensee has failed to ensure that a resident's plan of care provided clear direction related to mobility status.

Rationale and Summary:
A resident utilized an assistive device for mobility. The resident's plan of care identified two conflicting interventions related to the resident's required assistance level when ambulating with the assistive device.

An Registered Nurse (RN) and the Co-Director of Care (Co-DOC), confirmed that the interventions that had been identified in the resident's plan of care related to mobility status would not be considered clear direction.

The plan of care not providing clear direction resulted in low risk and no impact to the resident, as it was determined that staff were monitoring as needed related to this resident's mobility status.

Sources: A resident's plan of care; Interviews with an RN, and the Co-DOC. [000701]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care was reviewed and revised when a resident's care needs changed, related to falls prevention and management.

Rationale and Summary:
A resident sustained a fall resulting in injury, which resulted in a change in their mobility status and increased falls prevention interventions being utilized. After reviewing the resident's progress notes, and in interviews with a Personal Support Worker (PSW), an RN, and the Co-DOC, it was identified that new falls prevention interventions were being used; however, these

interventions were not identified in the resident's plan of care. As well, the staff indicated that this information should have been added to the plan of care for staff to know these interventions were being utilized.

Not having these falls prevention interventions identified in the resident's plan of care, resulted in low risk and no impact to the resident as it was determined that staff were utilizing these interventions for the resident post fall.

Sources: A resident's plan of care; Interviews with a PSW, an RN, and the Co-DOC. [000701]