

Inspection Report under the Long-Term Care Homes Act, 2007**Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**
Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 9, 2020	2020_853692_0007	017488-20, 017489-20	Follow up

Licensee/Titulaire de permis

The District of the Municipality of Muskoka
98 Pine Street BRACEBRIDGE ON P1L 1N5

Long-Term Care Home/Foyer de soins de longue durée

The Pines
98 Pine Street BRACEBRIDGE ON P1L 1N5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

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la Loi de 2007 sur les foyers de
soins de longue durée**

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 26-30 and November 2, 2020.

The Following intake(s) were inspected upon during this Follow Up Inspection:

-One log, which was related to compliance order #001 from inspection report #2020_615759_0016, where the home was ordered to comply with section 19 subsection 1 of the Long-Term Care Homes Act (LTCHA), 2007, related to the licensee ensuring that the residents of the home are protected from abuse by anyone and that they are not neglected, with a compliance due date of September 18, 2020; and,

-One log, which was related to compliance order #002 from inspection report #2020_615759_0016, where the home was ordered to comply with section 20 subsection 1 of the LTCHA, 2007, related to the licensee ensuring that the home's abuse policy is followed, with a compliance due date of September 18, 2020.

A Complaint Inspection #2020_853692_0006 and a Critical Incident System Inspection #2020_853692_0008 were conducted concurrently with this inspection.

Please note: A Written Notification and a Compliance Order related to s. 19 (1) was also identified in a concurrent inspection, Critical Incident System Inspection #2020_853692_0008, was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Housekeepers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, reviewed the home's internal investigation records, as well as licensee policies, procedures and programs.

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation**

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During the course of this inspection, Non-Compliances were issued.

1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2020_615759_0016	692

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NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend

WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order

Légende

WN – Avis écrit
VPC – Plan de redressement volontaire
DR – Aiguillage au directeur
CO – Ordre de conformité
WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD).

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19.
Duty to protect**

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

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1. The licensee has failed to ensure that the resident was protected from abuse by anyone.

Compliance order #001 related to s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007, from inspection 2020_615759_0016, issued on August 25, 2020, with a compliance due date of September 18, 2020, is being re-issued as follows:

Physical abuse is defined within the Ontario Regulations 79/10 of the LTCHA, 2007, as "the use of physical force by anyone other than a resident that causes physical injury or pain". Emotional abuse is defined as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

Two staff members witnessed a registered staff member, when intervening in a resident to resident altercation, use excessive force than was necessary, and had spoken to the resident in an inappropriate manner. During separate interviews with the Administrator and Director of Care (DOC), they both indicated that the registered staff member had been found to have abused the resident.

Sources: CIS report; the home's policy, "Zero Tolerance of Resident Abuse and Neglect Program; resident progress notes; the home's internal investigation notes; staffs personnel file; interviews with the Administrator, DOC and other staff. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".



**Ministry of Long-Term
Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère des Soins de longue
durée**

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 12th day of November, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.



**Ministry of Long-Term
Care**

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ministère des Soins de longue
durée**

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

**Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée**

Public Copy/Copie du rapport public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : SHANNON RUSSELL (692)

Inspection No. /

No de l'inspection : 2020_853692_0007

Log No. /

No de registre : 017488-20, 017489-20

Type of Inspection /

Genre d'inspection: Follow up

Report Date(s) /

Date(s) du Rapport : Nov 9, 2020

Licensee /

Titulaire de permis :

The District of the Municipality of Muskoka
98 Pine Street, BRACEBRIDGE, ON, P1L-1N5

LTC Home /

Foyer de SLD :

The Pines
98 Pine Street, BRACEBRIDGE, ON, P1L-1N5

Name of Administrator /

**Nom de l'administratrice
ou de l'administrateur :**

Kim Landry

To The District of the Municipality of Muskoka, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # /**No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / 2020_615759_0016, CO #001;
Lien vers ordre existant:

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the Long-Term Care Home's Act, 2007.

The licensee shall prepare, submit and implement a plan to ensure that residents of the home are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The plan must include, but is not limited to, the following:

a) how the licensee will ensure that residents of the home are protected from abuse by anyone, and are not being neglected by the licensee or staff.

Please submit the written plan, by quoting inspection number 2020_853692_0007 and Inspector Shannon Russell by email to SudburySAO.moh@ontario.ca by November 23, 2020.

Please ensure that the submitted written plan does not contain any personal information or personal health information.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was protected from abuse by anyone.

Compliance order #001 related to s. 19 (1) of the Long-Term Care Homes Act (LTCHA). 2007, from inspection 2020_615759_0016, issued on August 25,

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

2020, with a compliance due date of September 18, 2020, is being re-issued as follows:

Physical abuse is defined within the Ontario Regulations 79/10 of the LTCHA, 2007, as "the use of physical force by anyone other than a resident that causes physical injury or pain". Emotional abuse is defined as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

Two staff members witnessed a registered staff member, when intervening in a resident to resident altercation, use excessive force than was necessary, and had spoken to the resident in an inappropriate manner. During separate interviews with the Administrator and Director of Care (DOC), they both indicated that the registered staff member had been found to have abused the resident.

An order was made by taking the following factors into account:

Severity: There was actual harm to the resident, resulting from the registered staff member who had been founded to have used excessive physical force and caused emotional abuse towards the resident.

Scope: The scope of this non-compliance was isolated to this incident.

Compliance History: The licensee continues to be in non-compliance with s. 19 (1) of the LTCHA, resulting in a compliance order (CO) being re-issued. CO #001 was issued on August 25, 2020 (inspection #2020_615759_0016) with a compliance due date of September 18, 2020. In the past 36 months, two other COs were issued to different sections of the legislation, all of which have been complied.

Sources: CIS report; the home's policy, "Zero Tolerance of Resident Abuse and Neglect Program; resident progress notes; the home's internal investigation notes; staffs personnel file; interviews with the Administrator, DOC and other staff.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

(692)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

Dec 14, 2020

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION**TAKE NOTICE:**

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Ministry of Long-Term Care**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère des Soins de longue durée**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS**PRENEZ AVIS :**

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsb.on.ca.

Issued on this 9th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

Service Area Office /
Bureau régional de services : Sudbury Service Area Office