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: April 8, 2025
Inspection Number: 2025-1575-0003
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): April 1 and 2, 2025.
The inspection occurred offsite on the following date(s): April 3 and 4, 2025.
The following intake(s) were inspected:

- One intake regarding an Influenza A Outbreak; and,
- two intakes related to complaints submitted to the Director regarding long term care operations.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting of Abuse

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that allegations of resident neglect were reported to the Director. A Registered Nurse (RN) was made aware by a Personal Support Worker (PSW) that residents may have been neglected. Neither the RN, nor the Director of Care (DOC) reported the allegations to the Director.

Sources: Internal communication; and, interviews with staff.

WRITTEN NOTIFICATION: Symptom Monitoring

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

The licensee has failed to ensure that residents symptoms were monitored every shift.

A review of resident progress notes identified that a number of residents were not being monitored every shift for symptoms.

Sources: Resident progress notes; line list; licensee policies; and, interviews with staff.

COMPLIANCE ORDER CO #001 Dining and snack service

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) provide education to all nursing staff related to the roles and responsibilities outlined in the home's policies related to food and fluids. The home shall keep record of the education including the date of the education, what was covered, who provided the education, and list of attendees;
b) develop and conduct audits for a period of 4 weeks. Implement corrective action for any deficiencies that are identified during the auditing process. Documentation of the audits and action taken to correct deficiencies must be maintained.

Grounds

The licensee has failed to ensure that residents received the assistance and devices to eat and drink.

Rationale and Summary
An email was sent to the DOC alleging that certain residents did not receive foods or fluids during the shift. The RN indicated that trays had been left outside resident rooms on two specific dates, with no assistance provided to residents who were unable to leave their rooms.

The Inspector observed a resident in their room with a tray of lunch food; however, no

assistance was provided to the resident, and the assistive devices specified in the plan of care were not provided.

Sources: Resident's progress notes and care plan; internal communications; Inspector observations; and interviews with staff.

This order must be complied with by May 23, 2025

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Develop a plan that describes how the IPAC lead will ensure that the following IPAC practices and process are implemented within the home:
-ensuring that staff are appropriately selecting Personal Protective Equipment (PPE), and correctly donning and doffing the PPE
-ensuring that staff are completing hand hygiene where required
-ensuring that staff have access to PPE at the point of care. and that signage is accurate
-ensuring that the required steps are taken to reduce the risk of transmission for residents displaying signs and symptoms of infection.

Grounds

The licensee has failed to ensure that the IPAC standard and directives related to IPAC were implemented in the home.

a) The Inspector observed staff on all five home areas enter and exit resident rooms without the required PPE, including no eye protection or gowns.

The Inspector observed staff in close proximity to residents without their surgical masks covering their mouth and nose as required.

b) During observations of the home areas, the Inspector noted that some rooms that required staff to don additional PPE before entering the room, did not have the PPE readily available.

c) The Inspector noted that staff had missed key moments of hand hygiene.

d) The Inspector noted that resident rooms that had been removed from isolation still had signage in place directing staff to utilize additional PPE; and residents who were on additional precautions, had signage removed.

e) The Inspector noted residents that were to be on isolation were being removed from their rooms by staff without masks being offered; and seated in the common area, in close proximity to other residents.

Overall, the home did not ensure that staff had access to PPE, utilized the required PPE, completed hand hygiene at the appropriate times, that signage was in place to direct staff as to what additional PPE was required in specific resident rooms; and, that steps were taken to minimize the risk of transmission.

Sources: Inspector observations; resident progress notes; line lists; licensee policies; and, interviews with staff

This order must be complied with by May 23, 2025

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.