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: June 20, 2025
Inspection Number: 2025-1575-0005
Inspection Type: Critical Incident Follow up
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): June 10-13, and June 16 -19, 2025

The following intake(s) were inspected:

- Intake: Follow-up #: 1 - O. Reg. 246/22 - s. 79 (1) 8. related to Dining and snack service
- Intake: Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b) related to Infection prevention and control.
- Two Intakes: related to alleged abuse of a resident.
- Intake: related to an Outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1575-0003 related to O. Reg. 246/22, s. 79 (1) 8.
Order #002 from Inspection #2025-1575-0003 related to O. Reg. 246/22, s. 102 (2) (b)

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care: Notification of Substitute Decision Maker

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was promptly notified when the resident sustained an incident of alleged abuse.

A resident was involved in an incident of alleged physical abuse. The Substitute Decision Maker (SDM) as identified in the resident's health record was not notified of the incident until a week later.

Sources: A resident's progress notes; the home's investigation notes; home's policies titled "Plan of Care," last reviewed March 2025; and Notification of the Family/Substitute Decision-Maker" last reviewed June 2025; and an interview with the Director of Care (DOC) and other staff.

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that staff complied with the policy to promote zero tolerance of abuse and neglect of residents when an incident occurred to a resident that was witnessed by staff, was not immediately reported to the Director. The incident was not reported until one week later.

Sources: A resident's clinical records; Review of the home's policy titled "Zero Tolerance Policy for Abuse and Neglect Program", reviewed date March 25, 2025; Review of the home's internal investigation notes; and interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)

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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

The licensee has failed to ensure that reasonable grounds to suspect abuse was immediately reported to the Director.

An incident of suspected abuse towards a resident was witnessed on a specified date by staff and was not reported to the home until a week later, when another incident occurred.

Sources: Critical Incident Report; Review of a resident's clinical records; Review of the home's policy titled, " Immediate Response and Mandatory Reporting of Abuse or Neglect", reviewed date March 25, 2025; Review of the home's internal investigation notes; and an interview with the DOC and other staff.

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