Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

Original Public Report

Report Issue Date June 29, 2022
Inspection Number 2022_1575_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee

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

Long-Term Care Home and City

The Pines
98 Pine Street Bracebridge ON P1L 1N5

Lead Inspector

AMY GEAUVREAU (642)

Inspector Digital Signature

Amy Geauvreau
Digitally signed by Amy Geauvreau
Date: 2022.06.29 10:22:44 -04'00'

Additional Inspector(s)

SHANNON RUSSELL (692)

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 2-6, 2022

The following intake(s) were inspected:

- Two Complaint Logs, with a Critical Incident System (CIS) Intake, were related to an allegation of neglect, care and services, falls, and retaliation.
- Three CIS Intakes, related to falls with an injury.
- One CIS Intake, related to medication administration.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services
- Whistle-blowing Protection and Retaliation

INSPECTION RESULTS

WRITTEN NOTIFICATION CARE PLAN

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (7)

The licensee has failed to ensure, that a resident's care set out in the plan of care related to a medical treatment, was provided as specified in the plan.

Rationale and Summary

A resident was to receive a medical treatment and the treatment was not provided on a specific date.

The Director of Care (DOC) identified that the medical treatment should have been provided, and that staff should be following the resident's care plan.

Sources: Policy titled, "Plan of Care,"; review of resident's progress notes; review of medical orders; interview with Registered Practical Nurse (RPN), the DOC, and other staff. [#642]

WRITTEN NOTIFICATION CARE PLAN

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (9)

The licensee has failed to ensure that the provision of the care set out in the plan of care for a resident, related to medical treatments was documented.

Rationale and Summary

A resident was to receive medical treatments which were to be documented at specific intervals; however, documentation was missing.

The DOC identified that medical treatments should be documented when completed. However, after review with the DOC of the residents medical file, they acknowledge there was missing documentation of the provision of care set out in the plan of care for this resident.

Sources: Policy titled, "Plan of Care,"; review of resident's progress notes; review of medical orders; interview with the DOC, and other staff. [#642**]**

WRITTEN NOTIFICATION ORIENTATION

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 76 (2) 10.

The licensee has failed to ensure that a specific RPN had received training that was relevant to the person's responsibilities, and medication administration.

Rationale and Summary

After a medication administration incident, it was identified that an RPN had not completed a component of their mandatory education.

The DOC indicated that registered staff were assigned and expected to complete education prior to commencing on the units.

There was moderate risk to the residents by this RPN not completing the medication administration education.

Sources: CIS report; the home's internal investigation notes; the home's policy titled, "Pharmacy Services and Manual"; RPN's personnel file, including Learning records; interviews with another RPN, Registered Nurse (RN), and the DOC. [692]

WRITTEN NOTIFICATION POLICY DOCUMENTATION

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

Non-compliance with: O. Reg. 79/10, *s.* 8 (2)

The licensee has failed to ensure that the records required to be completed for a resident's unwitnessed fall, as required by the home's policy, were available to copy.

Rationale and Summary

A resident had unwitnessed falls where a, "Clinical Monitoring Record," should have been completed.

A review of the resident's medical file and a request for specific records, identified the records could not be located.

The DOC identified that the records for these incidents should have been completed as per the home's policy. The reports required to be completed were not available to copy for this resident.

Sources: Review of resident's health record; the home's policy titled, "Falls Prevention and Management Program"; and interviews with the DOC, and ADOC, and other staff. [#642]

WRITTEN NOTIFICATION POLICY, TO BE FOLLOWED

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

Non-compliance with: O. Reg. 246/22 s. 11 (1) (b)

The licensee has failed to ensure that the Falls Policies and Procedures were complied with, for a resident.

Rationale and Summary

In accordance with Ontario Regulation (O. Reg.) 226/22, s. 11 (1) (b), requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, program, procedure, the licensee is required to ensure that the plan, policy, program, procedure, (b) is complied with.

O. Reg. 226/22, s. 54 (1), required the licensee to ensure that the Fall Prevention and Management Program provided strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff had not complied with the home's policy, and procedure, by not utilizing the component of the "Clinical Monitoring Record," for a resident after an unwitnessed fall.

A resident had an unwitnessed fall; however, a component of the Clinical Monitoring Record was not completed.

Interview with the DOC identified that the process should have been completed for any unwitnessed fall as per the falls policy.

Sources: Review of resident's health record; the home's policy titled, "Falls Prevention and Management Program"; and interviews with the RPN, the DOC, ADOC, and other staff. [#642]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL

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

Non-compliance with: FLTCA, 2021 s. 23 (1) (4)

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.

Rationale and Summary

The DOC and Administrator identified that they were aware they were to have an IPAC lead. They both indicated that the home did not currently have an IPAC lead; therefore, they were both covering the position in addition to their duties.

There was moderate risk for all residents by the home not having an IPAC lead, whose primary role was the IPAC program ensuring the measures and requirements were implemented.

Sources: The home's policy titled, "IPAC program"; interviews with direct care staff, DOC, and the Administrator. [692]

WRITTEN NOTIFICATION MEDICATION ADMINISTRATION

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

Non-compliance with: O. Reg. 79/10, r. 129 (1) (b)

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked area.

Rationale and Summary

A medication pouch containing controlled substances and high alert medications was found in a location that was not double-locked.

The DOC identified that controlled substances were to be double locked and not accessible to other staff or residents. The DOC indicated the RPN had not stored the controlled substances as per the requirements, which would pose a moderate risk to residents

Sources: CIS report; the home's internal investigation notes; the home's policy titled, "Management of Insulin, Narcotics and Controlled Drugs"; interviews with RPNs, RN, and the DOC. [692]

COMPLIANCE ORDER CO #001 ADMINISTRATION OF DRUGS

NC#008 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 79/10. 131 (2).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 79/10. 131 (2).

The licensee shall:

A) Ensure that drugs are administered to the residents, specifically involved in this incident in accordance with the directions for use by the specified prescriber.

B) Ensure that any drug that is refused by a resident or not administered to a resident is disposed of and documented in their eMAR in accordance with the home's policy titled "Policy and Procedure, Medication Administration, Drug Wastage and Drug Destruction" policy.

Grounds

Non-compliance with: O. Reg. 79/10, r. 131 (2)

The licensee has failed to ensure that an RPN administered medications in accordance with the directions as specified by the prescriber.

Rationale and Summary

A medication incident report indicated multiple omissions of medications to multiple residents.

When this RPN did not administer prescribed medications to multiple residents, it put the residents at a high risk for a change in their health condition.

Sources: CIS report; the home's internal investigation notes; the home's policy titled, "The Medication Pass"; interviews with RPN, RN, and the DOC. [692]

This order must be complied with by July 15, 2022

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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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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Sudbury Service Area Office
159 Cedar Street, Suite 403
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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
email: 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.

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