Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2021	2021_853692_0010	025528-20, 001227-21, 002885-21, 006627-21	Critical Incident System

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Muskoka Shores Care Community
200 Kelly Drive Gravenhurst ON P1P 1P3

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

SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 17-21, 2021.

The following intake(s) were inspected upon during this Critical Incident System inspection:
-One log, which was related to a critical incident that the home submitted to the Director related to an unexpected death of a resident;

-One log, which was related to a critical incident that the home submitted to the Director related to Improper/incompetent treatment of a resident that resulted in harm or a risk of harm to the resident; and,

-Two logs, which were related to critical incidents that the home submitted to the Director related to incidents that caused an injury to a resident for which the resident was transferred to the hospital and resulted in a significant change in the residents status.

A Complaint Inspection #2021_853692_0009 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Nurse Managers (NMs), Physiotherapist (PT), 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, observed infection control practices, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

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

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

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

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. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purpose of section 35 of the Act, in accordance with section 112. 7. of the Ontario Regulation (O. Reg.) 79/10, that the following devices were not used in the home: Sheets, wraps, tensors or other types of strips or bandages, to restrain a resident.

A Critical Incident System (CIS) report was submitted to the Director, related to an allegation of improper or incompetent care of a resident. The CIS report indicated that an action had been taken to prevent a resident from rising to a standing position.

In an interview with a PSW, they identified to the Inspector that they had wrapped a specified item around a resident to keep the resident in a sitting position to prevent them from attempting to stand on their own.

The Director of Care (DOC) indicated during an interview that a specified item was not to be used in the home to restrict a resident's movement or to restrain a resident.

Sources: CIS report, the home's policy titled "Restraint Implementation Protocols", review of a resident's care plan and progress notes, review of the home's internal investigation notes, review of the PSW's personnel file, and Interviews with a PSW, DOC, and other staff members. [s. 35. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that no device provided for in the regulations is used to restrain the resident, to be implemented voluntarily.

Issued on this 14th day of June, 2021

[redacted]

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

Original report signed by the inspector.