

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 22, 2025

Inspection Number: 2025-1305-0002

Inspection Type:

Complaint

Critical Incident

Licensee: 2063412 Ontario Limited as General Partner of 2063412 Investment LP

Long Term Care Home and City: Muskoka Shores Community, Gravenhurst

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 7-11, and April 14-16, 2025

The following intake(s) were inspected:

- One Intake related to a medication incident.
- One Intake related to a disease outbreak.
- One Intake related to an unexpected death of resident.
- One complaint Intake related to alleged care concerns of a resident.
- One Intake related to an environmental hazard.

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

Resident Care and Support Services

Medication Management

Safe and Secure Home

Infection Prevention and Control

Reporting and Complaints

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Responsive Behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that a specialized assessment tool was completed for a resident on a specified date.

Sources: The resident's records; the licensee's policy; and interviews with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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); and

The licensee has failed to ensure that a resident with the presence of an infection

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was monitored every shift.

Sources: The resident's records; the licensee's policy; and interviews with the staff.

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