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: July 4, 2025
Inspection Number: 2025-1305-0003
Inspection Type: 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): June 23-27, 2025.

The following intake(s) were inspected:

- One intake related to the fall of a resident;
- One intake related to alleged improper care of a resident;
- One intake related to a medication incident/adverse drug reaction;
- One intake related to alleged abuse of a resident.

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

Medication Management
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The license has failed to ensure that when the care set out in a resident's plan of care was no longer necessary, it was revised.

A resident's care plan had contradicting information related to responsive behaviour interventions that had not been updated.

Sources: Review of the resident's plan of care and progress notes; and interviews with staff.

On June 27, 2025, the plan of care was updated to include the resident's current care requirements, related to responsive behaviours.

Date Remedy Implemented: June 27, 2025.

WRITTEN NOTIFICATION: Documentation

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

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A) The licensee has failed to ensure that the provision of care provided to an identified resident was documented following an incident of alleged abuse.

On the date of the incident, a social work referral was initiated for the resident. The referral was not completed until a period of time later, and there was no related documentation completed in that time.

Sources: Review of the social work referral for the resident; and interviews with staff.

B) The licensee has failed to ensure that the provision of care related to social work services provided to a second identified resident was documented following an incident of alleged abuse.

On the date of the incident, a social work referral was initiated for the resident. The referral was not completed until a period of time later, and there was no related documentation completed in that time.

Sources: Review of the social work referral for the resident; and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 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 actions were taken to respond to the needs of a resident who was displaying responsive behaviours.

The resident was involved in an incident on a specified date. The resident's care plan at the time of the incident indicated a specific behavioural intervention was to be in place at all times, however this was not in place when the incident occurred and the care plan had not been updated. As well, the resident was being monitored using a clinical tool at and around the time of the incident however significant periods over those dates were missing documentation.

Sources: Review of the resident's health records; and interview with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to an identified resident in accordance with the directions of the prescriber. The home's pharmacy provider was unable to supply the resident's medication right away, resulting in multiple missed doses of the medication.

Sources: The resident's clinical records, the home's policy; interviews with staff.

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The license shall:
A) Conduct a review of the written strategies, techniques, and interventions developed for the identified residents to prevent, minimize, and respond to their responsive behaviours. Ensure that the care plans provide clear direction to staff and account for the safety of the resident and other residents.

B) The Responsive Behaviour Lead for the home or designate shall conduct staff communication sessions on the respective units of the identified residents, encompassing all shifts, to discuss any corrections made in part A.

C) Record of part A and B shall be documented including the name of the person(s) responsible, date and time, attendees if relevant, and any corrective action taken. Documentation will be made available to the Inspector(s) upon request.

Grounds

A) The licensee has failed to ensure that the written strategies including techniques

and interventions met the needs of an identified resident with responsive behaviours and prevented, minimized, or responded to the responsive behaviours.

A resident sustained an injury on an identified date, and their plan of care indicated specific action. However, at the time of the resident's injury, and during the inspection, staff did not follow the specific action. Multiple staff indicated that the resident refused to have staff take the specific action, however this refusal was not documented or addressed by the home.

Sources: Inspector observations; health records for the resident; and, interviews with staff.

B) The licensee has failed to ensure that the written strategies including techniques and interventions met the needs of two residents with responsive behaviours and prevented, minimized, or responded to the responsive behaviours.

Prior to an incident involving the residents, the care plan of one of the residents was noted to have contradicting information related to responsive behaviour management and interventions involving the co-resident.

Staff indicated clear direction was not provided prior to the incident as to the two resident's interactions, which put the resident's at risk of harm.

Sources: Review of health records for the resident's; and interviews with staff.

This order must be complied with by August 15, 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.