

**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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de
Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2020	2020_824736_0024	010996-20	Complaint

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

AMANDA BELANGER (736)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 16-19, 2020.

**During the course of the inspection, the following log was inspected:
-one log, which was related to a complaint that was submitted to the home related
to an allegation of resident neglect.**

**During the course of the inspection, the inspector(s) spoke with the Executive
Director (ED), Director of Care (DOC), Registered Nurse(s) (RNs), Registered
Practical Nurse(s) (RPNs), and Personal Support Worker(s) (PSWs).**

**During the course of the inspection, the Inspector(s) conducted observations of
the home area(s), observed the provisions of care, observed staff to resident
interactions, reviewed relevant health care records, the home's complaint log,
internal investigation notes, as well as licensee policies, and procedures.**

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care**

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

2 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

**s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was turned and repositioned every two hours.

The home received communication that a resident who was required to be turned and repositioned every two hours, had not been. In interviews with both the Director of Care (DOC) and the Executive Director (ED), they indicated that during an internal investigation, it was determined that the resident was not turned and repositioned every two hours as they should have been.

Sources: the resident's care plan and support actions; the licensee's internal investigation notes; a licensee's policy; interviews with the PSW, DOC and ED, as well as other staff. [s. 50. (2) (d)]

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 to ensure that residents are turned and repositioned every two hours when they are unable to turn and reposition themselves, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).**
- 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. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that allegations of staff to resident neglect were immediately reported to the Director.

The home's ED received a written complaint alleging that neglect of the resident had taken place. The home did not complete a Critical Incident (CI) report to immediately notify the Director of the allegation of neglect. The ED indicated that the complaint was an allegation of neglect, and that the home followed the complaint process, not the abuse and/or neglect process.

Sources: licensee's internal complaint record; licensee's internal policy titled "MOHLTC-Duty to Report (ON), #XXIII-D-10.20, last revised June 2019; interviews with the DOC and ED. [s. 24. (1)]

Issued on this 26th day of November, 2020

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

Original report signed by the inspector.