Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 19, 2022
Inspection Number 2022_1511_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Mennonite Brethren Senior Citizens Home

Long-Term Care Home and City
Radiant Care Tabor Manor, St. Catharine's

Lead Inspector
Peter Hannaberg (721821)

Inspector Digital Signature
Peter Benjamin Hannaberg
Digitally signed by Peter Benjamin Hannaberg
Date: 2022.08.19 15:58:43 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 12-15, and 18-20, 2022.

The following intake(s) were inspected:

- Intake # 016967-21 (Complaint) related to witnessed physical abuse of resident by staff.
- Intake # 016473-21 (Complaint) related to alleged neglect and improper care.

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

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Safe and Secure Home

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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102(2)(b)

Upon inspection in July 2022, two resident rooms were missing additional precautions signage on the door. Inspector 721821 verified with staff that additional precautions for the residents was required. Once confirmed, registered staff posted the additional precautions signage on the doors for each resident room.

Sources: direct observations; interview with RPN #105.

Date Remedy Implemented: July 12, 2022

[721821]

WRITTEN NOTIFICATION RESIDENTS' BILL OF RIGHTS

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 3(1)8

The licensee has failed to ensure that a resident received privacy during their morning care as required by the Residents' Bill of Rights.

Rationale and Summary

On a morning in October 2021, an exchange between two staff and a resident was observed through the resident's window by a member of the public. The citizen called the Long-Term Care Home to express their concerns regarding what they had observed.

The resident and staff involved in the provision of care were identified. The Personal Support Workers (PSWs) were interviewed regarding the events of that morning. PSWs #111 and #112 stated that they forgot to close the blinds while care was being provided by them to the resident.

Critical Incident Report #3016-000007-21 stated that the PSWs forgot to close the blinds and they were reminded of the need to provide privacy during care per the Residents' Bill of Rights.

Sources: Critical Incident Report #3016-000007-21; interviews with the Director of Care (DOC) #100, PSW #111, and PSW #112.

[721821]

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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that the home had an infection prevention and control lead whose primary responsibility was the home's infection prevention and control program.

Rationale and Summary

The Director of Care (DOC) #100 stated during an interview that the home did not have a dedicated infection prevention and control (IPAC) lead at the time of inspection. DOC #100 stated that the IPAC responsibilities were shared between their self and the Assistant Director of Care (ADOC) #117.

There was a risk to residents' safety that elements of the IPAC program were overlooked since there was no designated IPAC lead.

Sources: interview with DOC #100.

[721821]

WRITTEN NOTIFICATION AIR TEMPERATURE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24(3)

The licensee has failed to ensure that the temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary

Maintenance Manager (MM) #101 provided air temperature logs from January to July of 2022. It was documented that air temperatures had been measured and recorded in the morning and afternoon in two resident rooms and one common area on each floor of the home. The records did not show any temperatures measured and recorded in the evening or night-time.

MM#101 stated that air temperatures were supposed to be measured and recorded by nursing staff in the evening since the maintenance staff were not present in the home after 1500 hours. The Director of Care (DOC) #100 stated that the nursing staff were not recording air temperatures in the evenings, and that no records could be produced.

Sources: Air temperature and humidity records for common areas and resident rooms; interviews with Maintenance Manager #101, and Director of Care #100.

[721821]