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

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Original Public Report

Report Issue Date: August 30, 2024

Inspection Number: 2024-1615-0002

Inspection Type:
Complaint
Critical Incident

Licensee: The Regional Municipality of Halton

Long Term Care Home and City: Post Inn Village, Oakville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 13, 14, 17-21, 24-28, 2024 and July 2-4, 8, 9, 2024.
The inspection occurred offsite on the following date(s): July 10, 2024
The following intake(s) were inspected:

- Intake: #00111957 Complaint related to alleged verbal/emotional abuse, neglect, plan of care, skin and wound care, continence care and bowel management, personal care, oral care, foot care and nail care.
- Intake: #00114253 Complainant related to dining and snack service, laundry service, complaint management process.
- Intake: #00114832 Critical Incident (CI) - related to falls prevention and management.
- Intake: #00115681 Critical Incident (CI) - related to respiratory outbreak.

The following intake was completed in this inspection:

- Intake: #00109524 Critical Incident (CI) - related to falls prevention and management.

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

Continence Care
Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident;

The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care related to dentures.

Rationale and Summary:
An identified resident was wearing dentures. Personal Support Workers (PSW) stated that if a resident wore dentures that information was to be posted on a yellow card on the inside of the resident's cupboard. A PSW confirmed with the Inspector that there was no information about the resident's dentures posted inside their cupboard. The resident's care plan and Kardex also did not identify that the resident wore dentures.

A Registered Practical Nurse (RPN) stated that information related to dentures was supposed to be on the yellow card on the inside of the residents' cupboards and may have been missed.

When staff do not have information about dentures, appropriate care for the dentures may not be provided.

Sources: the clinical health record, including care plan, Kardex; observations by the Inspector; and interview with PSWs and RPN.

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

A) The licensee has failed to ensure there was a written plan of care that set out

clear directions to staff and others who provided direct care to a resident, specific to the provision of a nutritional intervention.

Rationale and Summary:
A resident had a Care Plan (Hydration Focus) that indicated a specific item was to be served with each meal. The resident's Care Plan (Nutrition Focus) and the dining room choice sheet indicated the resident disliked that specific item.

The Registered Dietitian confirmed the inconsistent information may be confusing for staff.

The discrepancies in the care plan and the choice sheet provided unclear direction to staff, placing the resident at risk of not meeting their hydration and nutrition goals.

Sources: Nutrition Focus/Hydration Focus in a resident Care Plan, Choice Sheet, interview with staff.

B) The licensee has failed to ensure that the written plan of care for a resident set out clear directions for staff and others who provided direct care to the resident related to toenail care.

Rationale and Summary:
The plan of care for a resident directed staff to ensure that the resident's hair was washed and fingernails were cleaned and trimmed on bathing day. The plan of care did not provide direction related to toenail care. The home's "Resident Hygiene and Personal Care Procedure" directed staff to provide foot care as part of the shower/bath routine.

Personal Support Workers (PSW), who cared for the resident, stated that PSWs did

not trim toenails and a Registered Practical Nurse (RPN) stated that all residents had their toenails trimmed by the Foot Care Nurse. During interview, the Foot Care Nurse confirmed they did not provide toenail cutting services for the resident.

When clear direction for toenail care was not provided to staff through the written plan of care, not all staff were aware they were required to care for the resident's toenails.

Sources: plan of care for a resident; interview with PSWs, RPN, Foot Care Nurse; procedure "Resident Hygiene and Personal Care" 06-04-05, last revised July 2023.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and on the needs and preferences of that resident, specific to a positioning aid.

Rationale and Summary:
Interviews with Registered Practical Nurses (RPN) and a Personal Support Worker (PSW) confirmed the PSWs refer to the care plan as their first line resource to obtain directions on the care that is provided for residents.

Interviews with a PSW and RPN confirmed that the resident:
1) Required a positioning aid for comfort as per the Substitute Decision Maker's (SDM) preference and request.
2) Required another positioning aid to be in place while seated on the wheelchair as per the Occupational Therapist's assessment.

The resident's care plan in Point Click Care (PCC) did not provide direction for either positioning aid. Both interventions should have been documented in the resident's care plan in Point Click Care (PCC), which was acknowledged by a PSW, and three RPNs. The Nurse Manager further confirmed the SDM's preferences should have been captured in the care plan.

A PSW reported there had been instances where the comfort aid was not in place and was discovered by the SDM.

The Occupational Therapist (OT) reported the resident was found seated in a wheelchair without the positioning aid in place during their assessment.

When the positioning aids were not identified in the resident's care plan, staff may not have been aware of the care that was required for the resident, which posed a risk for discomfort and/or skin breakdown.

Sources: Interviews with staff, a resident's clinical records.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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; or

The licensee failed to ensure that the plan of care for a resident was reviewed and revised when the resident's care needs changed and care set out in the plan was no longer necessary related to continence.

Rationale and Summary:
The plan of care for a resident directed staff to check and change the resident before lunch. The resident was not checked or changed before lunch when observed by the Inspector. Personal Support Workers (PSW) stated the resident required checking/changing after lunch. The Registered Practical Nurse (RPN) stated that the resident had a change in their condition and was no longer as frequently incontinent and after lunch was appropriate. The RPN stated that the plan of care had not been updated to reflect the change.

Sources: observations of the resident; interview with PSWs, RPN; the clinical health record for a resident, including plan of care.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
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,
(c) care set out in the plan has not been effective.

The licensee failed to ensure that a resident was reassessed and their plan of care reviewed and revised when the care set out in the plan of care was not effective in relation to falls prevention and management strategies.

Rationale and Summary:
The falls prevention and management plan of care for a resident included specific fall prevention strategies. The resident had a fall, which resulted in an injury.

During interview, Personal Support Worker (PSW) and Registered Practical Nurse (RPN), who attended the resident after the fall, stated that the resident did not have the fall prevention strategies in place at the time of the fall. The RPN stated that the strategies were not being used as the resident was consistently refusing them and they were not effective. The RPN stated the interventions should have been removed from the resident's plan of care.

If the resident was reassessed and their plan of care revised, other fall prevention strategies may have been considered to prevent the resulting fall with injury.

Sources: Clinical health record for a resident, including progress notes, care plan, and assessments; interview with PSW and RPN.

WRITTEN NOTIFICATION: Care conference

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (b)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,

(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and

The licensee failed to ensure that a resident was given an opportunity to participate fully in their care conference.

Rationale and Summary:
A six week care conference was held for a resident. Documentation from the care conference identified that the resident did not attend the meeting. The RPN confirmed the resident did not attend the meeting and stated that it was up to the family to decide if residents were invited or attended the care conferences.

During interview, the resident confirmed they had not been invited to attend the care conference and stated they would have liked to go to the meeting. The resident stated that there wouldn't be a way to express their concerns if they weren't there at the meeting.

When the resident was not invited to attend their care conference they were not provided the opportunity to fully participate in the development, implementation, review and revision of their plan of care.

Sources: the resident's clinical health record, including the six-week care conference, assessment and progress notes; interview with the resident and RPN.

WRITTEN NOTIFICATION: General requirements

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions, and the resident's responses to interventions were documented.

Rationale and Summary:
Review of a resident's records and interview with the Occupational Therapist (OT) confirmed that the resident required a positioning aid when seated on their wheelchair.

The OT reported they observed the resident seated on their wheelchair without the aid during an assessment. The OT responded by informing a nurse on the unit, whose name could not be recollected during the interview. No further action was performed by the OT.

Review of the resident's clinical records and progress notes did not include any documentation that the device was absent while the resident was seated on the wheelchair, nor was there mention of an action plan to rectify the problem.

Two RPNs confirmed this should have been documented in the progress notes by the OT or the nurse it was reported to.

The home's policy titled "Standards for Documentation", last revised November 2023, indicated documentation was to be completed by the individual who performed the action or observed the event and the primary documentation system

for recording health information was the electronic health record for the resident in Point Click Care (PCC).

When the OT's assessment of the missing aid was not documented, there was a lack of communication with the multidisciplinary team. This may have resulted in increased risk of impaired skin integrity. Furthermore, the problem was identified, but was not action planned to prevent the risk of future similar occurrences.

Sources: Interviews with staff, review of a resident's clinical records, the home's policy titled "Standards for Documentation", last revised November 2023.

WRITTEN NOTIFICATION: Foot care and nail care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (1)
Foot care and nail care
s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The licensee failed to ensure that each resident of the home received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Rationale and Summary:
The home's "Resident Hygiene and Personal Care Procedure" directed staff to provide foot care as part of the shower/bath routine.

The Inspector observed a resident the day after their shower and the resident's

toenails needed trimming. Documentation did not include evidence that the resident's toenails had been trimmed over an almost three-month period.

Personal Support Workers (PSW) stated that PSWs do not trim toenails. One PSW stated that the resident had their nails trimmed by the Foot Care Nurse and the Registered Practical Nurse (RPN) stated that all residents had their toenails trimmed by the Foot Care Nurse.

During interview, the Foot Care Nurse stated that visits for toenail cutting were scheduled every six to eight weeks and confirmed they did not provide toenail cutting services for the resident.

When staff are not providing toenail care there is a risk of discomfort and infection for residents.

Sources: a resident's clinical records for bathing and nail care; interviews with PSWs, RPN, and the Foot Care Nurse; procedure "Resident Hygiene and Personal Care" 06-04-05, last revised July 2023.

WRITTEN NOTIFICATION: Personal items and personal aids

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)

Personal items and personal aids

s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,

(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee failed to ensure that a resident had their personal aid labelled within 48 hours of acquiring.

Rationale and Summary:
Review of a resident's records and interview with a Registered Practical Nurse (RPN) confirmed that the resident's personal aid was not labelled and went missing on an unknown date. It was assumed the aid went missing during laundry service cleaning. The home found the aid in another resident's room.

The Nurse Manager acknowledged the resident's personal aid should have been labelled to reduce the risk of misplacing the item.

Failure to follow the home's lost and found procedure by not labelling the personal aid contributed to the misplacement of the item.

Sources: Progress notes, Lost and Found policy Procedure # 15-02-02-11, last revised April 6, 2018, interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a

clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that a resident, who exhibited altered skin integrity, received a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary:
Progress notes identified a resident had areas of skin impairment. Documentation did not reflect an assessment of these areas using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The home's procedure for the management of residents with skin impairment directed staff to initiate a baseline wound assessment and document the findings in the Nurse-Skin and Wound Assessment and Designate RN Referral and the Nurse-Skin Tear Assessment (STAR).

The Registered Practical Nurse (RPN) stated that the areas of skin impairment required assessment using the noted assessment forms and confirmed that the assessments had not been completed for the identified areas of skin impairment.

When a standardized assessment instrument is not used for the assessment of impaired skin integrity, there is a risk that not all necessary information will be included in the assessment.

Sources: clinical health record for a resident, including assessments, progress notes, treatment records; interview with RPN; procedure, 17-03-02, "Prevention,

Identification and Management of Residents with Altered Skin Integrity", last revised September 2019.

WRITTEN NOTIFICATION: Skin and wound care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that a resident, who was exhibiting altered skin integrity, was reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated.

Rationale and Summary:
a) A new area of skin impairment was identified on a resident with a referral to the Wound Care Registered Nurse (RN) for assessment. Registered Practical Nurse (RPN) and Wound Care RN stated the area required weekly wound assessments.

The home's skin and wound management procedure directed staff to document weekly wound assessments in the Weekly Wound Assessment progress notes. There were no documented Weekly Wound Assessment progress notes for the area of skin impairment.

A Registered Practical Nurse (RPN) stated that when weekly monitoring was

required, it was to be added to the electronic Treatment Administration Record (eTAR). The RPN confirmed that the area had not been added to the resident's eTAR. The Wound Care RN and RPN confirmed the weekly wound assessments had not been completed.

b) Progress notes identified additional skin impairment for the resident. A Registered Practical Nurse stated that the identified impairment required weekly assessment. The RPN stated the impairment was added to the eTAR for treatment, however, a weekly wound assessment had not been added to the eTAR and Weekly Wound Assessment progress notes had not been completed.

When weekly skin and wound assessments are not completed there is a risk of the areas deteriorating.

Sources: a resident's clinical health record, including assessments, progress notes, Physician orders, treatment records; interview with the Wound Care RN, RPNs; procedure, "Prevention, Identification and Management of Residents with Altered Skin Integrity", 17-03-01, revised September 2019.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee has failed to ensure that the nutrition and hydration programs included

the implementation of interventions to mitigate and manage risks, specific to making use of the choice sheets to monitor residents' choices and to monitor that residents had been served meals.

Rationale and Summary:
Nutrition Service Supervisors reported that Personal Support Workers (PSW) were responsible for using the choice sheet at each meal to monitor residents' meal choices and to monitor that residents had been served meals. This aligns with the home's "Dining, Snacks, and Services" procedure, which indicated resident meal choice would be recorded on menu choice sheets.

The staff within the home had not used the choice sheets to record resident meal selections and the following was observed during lunch meal observations:
a) A PSW confirmed they did not use the choice sheet to record residents' meal choices as they made a mental note of resident meal choices. The PSW reported they did not use a choice sheet to keep track of menu selections and meal service as they had not seen it used by other staff members.

b) A resident was seated in the dining room and when the entree was served, the resident reported they did not receive their soup prior to the hot entrée. One PSW reported they assumed the resident was served soup by the other PSW working in the dining room. The PSW confirmed the only way they knew soup was not served to the resident was because the resident spoke out about it. The PSW explained that PSWs assign a server amongst themselves and keep track of resident choices and meal service by making a mental note. They confirmed a choice sheet existed but was not implemented.

Failure to implement the choice sheets to monitor if residents have been served and to capture meal choices, places residents at risk for a delayed or missed meal course which impacts pleasurable dining.

Sources: Mealtime observations, interviews with staff, The home's policy titled "Dining, Snacks, and Services Procedure # 10-03-09", last revised December 2023.

WRITTEN NOTIFICATION: Menu planning

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that the planned menu items were offered and available at each meal.

Rationale and Summary:
A resident's hydration and nutrition focus in their care plan indicated they were to be provided specific beverages at meals.

Observations by the Inspector in the dining room showed that three of the four specific beverages were not provided to the resident at the meal. This was confirmed by a PSW and Dietary Aide.

Failure to provide the resident with the care planned fluid interventions may have increased their risk for hydration inadequacy as opportunities to consume beverages were reduced.

Sources: Observations conducted in the dining room, interviews with staff, clinical records.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to carry out every standard or protocol issued by the Director with respect to infection prevention and control, the Director's issuance was complied with.

A) In accordance with the Infection Prevention and Control (IPAC) Standard for long-term care homes, Standard 10.1, the licensee was required to ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary:
During the inspection, the Inspector received a bottle of Isagel Coloplast Alcohol Based Hand Sanitizer (ABHR) from the Administrative Assistant. The label showed it consisted of 60% ethyl alcohol.

The Infection Prevention and Control (IPAC) Lead confirmed the Isagel Coloplast ABHR was located in several areas within the home, including medication carts, treatment carts, snack carts, and Point of Care (POC) charting hubs. The IPAC Lead acknowledged the minimum percent alcohol should be 70%; but made use of the product due to having a surplus available within the home.

Availability of 60% alcohol concentration-based hand sanitizer easily accessible at

both point of care and in other common and resident areas posed a risk of transmission of infectious agents.

Sources: Observations, Isagel Coloplast Ethyl Alcohol No Rinse Antiseptic Gel label, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, interviews with staff.

B) The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, was implemented.

Rationale and Summary:
The IPAC Standard for Long-Term Care Homes indicated, under section 9.1 f), that the licensee shall ensure that Additional Precautions were followed in the IPAC program, including appropriate selection application, removal and disposal.

Two Personal Support Workers (PSW) donned only gloves, assisted a resident with their incontinence product, and disposed of the resident's soiled incontinence brief. There was signage outside the resident's room that identified additional contact precautions were required and directed staff to wear a gown and gloves. A Registered Practical Nurse (RPN) and the IPAC Lead confirmed the resident required contact precautions and stated that staff should have worn a gown in addition to gloves when they were handling the resident's brief and assisting the resident.

When staff do not follow the required additional precautions, there is risk of transmitting infections to residents and staff.

Sources: observations; interview with PSWs, RPN and IPAC Lead; contact precaution signage outside the resident's room; and Inter-office memorandum to nursing staff from IPAC Lead related to new resident care caddies and IPAC Education for Contact Precautions.

WRITTEN NOTIFICATION: Dealing with complaints

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was provided with a response that included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary:
A verbal complaint was made to the Administrator by a resident's Substitute Decision Maker (SDM) regarding the care of a resident and the operation of the home.

An e-mail was later sent to the Administrator by the resident's SDM. The e-mail identified concerns related to the care of a resident and the operation of the home. A Nurse Manager led the complaint investigation and provided a verbal update to the family.

The Administrator confirmed the update provided to the family did not include the

Ministry's toll-free telephone number for making complaints about homes.

The home's failure to provide the complainant with the Ministry's toll-free telephone number for making complaints did not comply with the complaints procedure requirements under the Ontario Regulation 246/22 under the Long Term Care Act 2021.

Sources: Complainant e-mail, interview with the Administrator, Complaint Log

WRITTEN NOTIFICATION: Dealing with complaints

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee has failed to ensure that a documented record was kept in the home that included a description of the response provided to the complainant.

Rationale and Summary
A verbal complaint was made to the Administrator by a resident's Substitute Decision Maker (SDM) regarding the care of a resident and the operation of the home.

An e-mail was sent to the Administrator by the resident's SDM. The e-mail identified concerns related to the care of a resident and the operation of the home.

A Nurse Manager led the complaint investigation and provided a verbal update to the family.

The Administrator confirmed there was no written record of the response provided to the complainant.

The home's failure to ensure a documented record was kept in the home that included the response provided to the complainant did not comply with the complaints procedure requirements under the Ontario Regulation 246/22 under the Long Term Care Act 2021.

Sources: Complainant e-mail, interview with the Administrator, Complaint Log