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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: September 26, 2024	
Inspection Number: 2024-1618-0004	
Inspection Type: Complaint Critical Incident	
Licensee: The Regional Municipality of Halton	
Long Term Care Home and City: Creek Way Village, Burlington	
Lead Inspector	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 26, 27, 28, 29, 30, 2024 and September 3, 2024.

The following intake(s) were inspected in this critical incident (CI) inspection

- Intake: #00125398 -Critical Incident (CI)- M623-000018-24 - Related to Prevention of Abuse and Neglect.

The following intake(s) were inspected in this complaint inspection:

- Intake: #00124362 -Complainant with concerns regarding Prevention of Abuse and Neglect.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that the 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 was reported to the Director immediately.

Rationale and Summary
On a day in August 2024, the home's manager was informed in writing about an alleged witnessed abuse.

The manager acknowledged they received the written complaint during their absence and the incident was not immediately reported to the Director.

Sources: Resident's Clinical records, CI # M623-000018-24 Reporting and Managing Complaints. interview with Administrator and Manager.

WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 1.
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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure that they provided a response within ten business days after receiving the complaint.

Rationale and Summary
An alleged abuse was reported to the home in writing but the home did not provide a response to the complaint within the ten day period of receiving the complaint.

Staff acknowledged that the standard response time to the complainant is within

ten business days, and they were in the process of notifying the complainant about the response at the earliest.

There was a potential risk to the resident when a concern was not promptly addressed and investigated.

Sources: Resident's Clinical records, CI # M623-000018-24, Reporting and Managing Complaints, Interview with Administrator and Manager.