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

Ottawa District
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Original Public Report

Report Issue Date: Sept 5, 2024
Inspection Number: 2024-1460-0002
Inspection Type: Complaint Critical Incident
Licensee: AON Inc.
Long Term Care Home and City: Moira Place Long-Term Care Home, Tweed

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3, 4, 5, 2024

The following intake(s) were inspected:

- Intake: #00124478 - CIS #2977-000005-24 -Fall of resident resulting in injury.
- Intake: #00124880 - Complainant related to a resident fall.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

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

The licensee has failed to ensure that the transfer logo, staff assignment sheet and care plan provide clear and correct information regarding the residents care.

Sources:

Review of residents plan of care, transfer logo's, and staff assignment sheets. Observations of transfer logos and resident. Interview with staff.

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)
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.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

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,

ii. an explanation of,

A. what the licensee has done to resolve the complaint, or

B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that a verbal complaint, that was received on a specific date, to the licensee regarding a fall of a resident was investigated or responded to as per the regulations.

Sources:

Review of resident progress notes. Interview with the complainant and DOC.

WRITTEN NOTIFICATION: Reports re: Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that a fall with injury of a resident resulting in a transfer to hospital and significant change was reported within the required timelines. The report was made 3 days later than required.

Sources:

PSW documentation and progress notes. Review of Critical Incident report. Interview with staff.