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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Public Report

Report Issue Date: March 11, 2025
Inspection Number: 2025-1460-0001
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): March 5, 6, 2025

The following intake(s) were inspected:

- Intake: CIS# 2977-000004-25 - Responsive behavior of a resident resulting in discharge from LTCH.
- Intake: #00141234, #00141242, #00141405, #00141561 - Complaint with concerns related to a resident discharge.

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

Infection Prevention and Control
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Police Record Checks

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 81 (2)
Screening measures
s. 81 (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age.

The licensee has failed to ensure that a a Police record check was conducted for two specific staff on hire.

Sources:
Failure to produce a Police record check; interview with Administrator and DOC.

WRITTEN NOTIFICATION: Training

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.

8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The licensee has failed to ensure that two specific staff at the home have received training as required by this section.

Sources:
Interview with the DOC and Administrator.

WRITTEN NOTIFICATION: Requirements on Licensee before discharging a resident.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into

consideration; and
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

The licensee has failed to meet the above requirements prior to discharging them from the LTCH. A resident was transferred to hospital for assessment related to a responsive behavior incident at the LTCH on a specific date. Resident was discharged from the LTCH on a specific date. There was no communication with the Hospital or placement coordination services regarding alternative accommodation for the resident prior to discharge. There was no written notice to the resident or SDM. There was communication with the SDM related to potential discharge. Also no alternatives were explored prior to discharge of the resident.

Sources
Resident record review and interview with DOC and Administrator.