



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**

**Division des foyers de soins de  
longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
May 24, 2018	2018_605213_0006	005602-18, 006677-18	Complaint

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**Licensee/Titulaire de permis**

ATK Care Inc.  
1386 Indian Grove MISSISSAUGA ON L5H 2S6

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**Long-Term Care Home/Foyer de soins de longue durée**

Exeter Villa  
155 John Street East EXETER ON N0M 1S1

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

RHONDA KUKOLY (213)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): April 30 & May 1, 2018**

**This inspection was completed related to complaint infoline #IL-56313-LO and critical incident #2749-000003-18 related to alleged improper treatment of a resident that results in harm or risk of harm to a resident.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse, Personal Support Workers, residents and family members.**

**The Inspector also made observations and reviewed health records for identified residents, relevant policies and procedures, education records, internal investigation records and other relevant documentation.**

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**0 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Findings/Faits saillants :**

1. 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 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 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. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

The licensee also failed to ensure that the documented record regarding complaints was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record kept of each review and of the improvements made in response.

The home reported critical incident report #2749-000003-18 on an identified date, regarding an incident where resident #001 received an injury during care that same day. The family was advised of the incident and as a result, voiced a concern to the home. The home initiated a "Resident/Family Complaint" form on the date of the incident.

The critical incident report indicated that that the home initially met with family related to their complaint six days following the incident, completed an investigation and put interim measures in place.

The home's internal investigation records were reviewed and indicated that the home initially met with family related to their complaint five days following the incident, completed an investigation and put interim measures in place.

The "Resident/Family Complaint" form was reviewed greater than 10 business days after the incident and the "Follow-up" section was blank.

The policy "Complaint procedure" with a revised date of May 1, 2018 was reviewed and included:

The Administrator will respond in writing within 10 days.

For those complaints that cannot be resolved in 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.



Added May 1, 2018: "Complaints will be reviewed quarterly using the Complaint Tracking Tool" and "the complaints will be summarized quarterly by the Administrator following the table format. The results will be shared with the leadership team".

In an interview with resident #001's family, they said that the home arranged a meeting with the family to discuss their concern six days following the incident. All of the family requested to attend the meeting were not able to attend and the home agreed to reschedule the meeting. As of the inspection, the meeting had not occurred or been rescheduled. The family said that they had not been advised of the resolution to date.

In interviews with three staff members, they all stated that the interim measures are still in place and that to their knowledge, there had been no resolution to the concern.

In an interview with the Administrator #102, they said that interim measures were put in place until the home could meet with the family and determine final resolutions to the issue. The Administrator agreed that the meeting had not occurred or been scheduled yet, greater than 10 business days after the initially scheduled meeting. These interim measures were still in place at the time of the inspection. When asked if complaints were reviewed or analyzed for trends and in determining what improvements were required in the home, the Administrator said that this was done annually. There was no documentation of a quarterly review or analysis of complaints quarterly.

The licensee has failed to ensure that for complaints that could not be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint was 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 provided as soon as possible in the circumstances when it was determined that a meeting with family was required for a final resolution and the meeting had still not been rescheduled greater than 10 business days after an initially scheduled meeting. The licensee also failed to ensure that the documented record regarding complaints was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record kept of each review and of the improvements made in response. [s. 101.]



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**Issued on this 24th day of May, 2018**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**