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

Central West District
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Public Report

Report Issue Date: February 25, 2025

Inspection Number: 2025-1211-0001

Inspection Type:
Complaint
Critical Incident

Licensee: 488491 Ontario Inc.

Long Term Care Home and City: Avalon Retirement Centre, Orangeville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12, 14, 20, 21, 24, 2025
The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) were inspected:

- Intake: #00132183/CI #2715-000034-24 - Prevention of Abuse and Neglect
- Intake: #00132695/CI #2715-000035-24 - Injury of an Unknown Cause
- Intake: #00134119/CI #2715-000037-24 - Fall Prevention and Management
- Intake: #00139244 - Complainant related to Palliative Care

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Palliative Care
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect two residents from abuse by a staff member.

Section 2 (a) of the Ontario Regulation 246/22 defines sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

A staff member acted inappropriately towards two residents, on two separate occasions resulting in the residents feeling uncomfortable.

Sources: the home's internal investigation, progress notes, interviews with the Director of Care (DOC) and other staff.

WRITTEN NOTIFICATION: Complaints Procedure — Licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (a)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,

(a) ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints;

The licensee failed to ensure that there were written procedures that complied with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

The home's complaint policy did not include written procedures for providing required information to complainants that complied with Ontario Regulation section 108 (1) 3.

When the home's complaints procedure did not comply with the regulations for how the licensee deals with complaints, complainants were not provided all of the required information.

Sources: Concern/Complaint forms, LTC Concerns and Complaints Management Policy (July 8, 2024), interview with the DOC.

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee was directed to update a critical incident (CI) report with the results of the home's internal investigation, once available.

The most recent amendment to the CI did not document the results of the home's internal investigation.

Sources: CI report, interview with the DOC.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it is based to the Director.

A resident had an injury of unknown cause resulting in a suspicion of incompetent care which was not immediately reported to the Director.

There was an increased risk to residents when the home failed to immediately report the suspicion of improper or incompetent treatment or care that resulted in harm to a resident.

Sources: resident progress notes, interview with the DOC.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #005 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 comply with s. 28 (1) 2. in that a staff member who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 28 (1) 2 of the FLTCHA.

Pursuant to s. 154 (3) the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

Staff did not immediately report an allegation of abuse resulting in a second incident of alleged abuse occurring.

Sources: the home's Abuse - Zero Tolerance Policy for Resident Abuse and Neglect, the home's internal investigation, interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee failed to ensure that a resident, who was dependent on staff for repositioning, was repositioned every two hours or more frequently, as required by their plan of care.

Staff did not turn and reposition a resident on one occasion.

When the resident was not turned and repositioned as required by their plan of care, their needs were not met.

Sources: point of care documentation, the home's internal investigation, interview with the DOC and others.