Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 10, 2016	2016_293554_0013	016632-16, 018334-16, 018824-16	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

BALLYCLIFFE LODGE NURSING HOME
70 STATION STREET AJAX ON L1S 1R9

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

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 20-22, 24, 28-30 and July 04-05, 2016

The following intakes were reviewed and inspected upon during this inspection: #016632-16, #018824-16, and #018334-16.

Summary of Intakes:

1) 016632-16 - Complaint - regarding care not being provided as per the plan of care, specifically for resident #003; and the complainant is concerned about a power outage which affected the long-term care home during May 2016.

2) #018334-16 - Complaint - regarding care not being provided as per the plan of care, specific to residents #001 and #002.

This inspection report contains an area of non-compliance under LTCHA, 2007, s. 6 (7), specific to resident #011; evidence for the non-compliance is found in inspection report #2016_178624_0015, which was completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Director of Operations, Nurse Consultant, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping Aide, RAI-Coordinator, Behaviour Support Staff, Quality Nurse, Environmental Services Manager, Family Council President, Chair/Secretary, Residents, and Family.

During the course of the inspection, the inspector, toured the home, reviewed clinical health records, identified critical incident reports, home's investigational notes, complaints log workbook; observed staff-resident interactions; reviewed staffing contingency plans; reviewed home specific policies, specifically, Complaints, Medication Administration, Responsive Behaviours, and the Emergency Response Plan, relating to power outage.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

- **4 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (2), by not ensuring the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Related to Intake #018334-16, for Resident #002:

Substitute Decision Maker (SDM) #007 indicated being told, on a specific date, that resident #002 would require a specific treatment for a period of approximately two weeks.

Resident #002 has a cognitive impairment. According to the clinical health record, resident #002's attending physician ordered a specific treatment on an identified date. According to the plan of care, the use of the treatment was to be reassessed in two weeks.

The clinical health record, for resident #002, provides documentation of the following:
- Altered skin integrity
- Identified area is slow to heal; a specific treatment was ordered on an identified date, to aid with healing. The treatment was in use for resident #002 during the period of approximately one and a half months.
- On an identified date, the attending physician ordered a laboratory specimen to be collected and sent to laboratory to rule out an infection. The laboratory specimen was

collected and sent to the laboratory on the date which it was ordered.
- Two days later, resident #002 was experiencing identified symptoms. Resident #002 was assessed by the Nurse Practitioner and orders were received to push fluids, monitor output and a prophylactic antibiotic was ordered for suspected infection; the Nurse Practitioner ordered a second laboratory specimen to be obtained. Substitute Decision Maker was notified of suspected infection and orders for new medication to be started. The ordered medication was administered for a seven day period as directed by the physician. Progress notes provided documentation supporting that a laboratory specimen was obtained and sent to the laboratory on the date in which it was ordered.
- On a specific date, approximately month and a half later, the attending physician, for resident #002, ordered the identified treatment to be discontinued.

Registered Practical Nurse #105, who works as the charge nurse, in the resident home area where resident #002 resides, reviewed the clinical health record for resident #002, and confirmed that there was no indication that identified treatment for resident #002 was reassessed, during the two week period. RPN #105 further indicated there is no indication that the long-term care home received test results for the laboratory specimens sent on two identified dates. RPN #105 indicated that the clinical health record for resident #002 did not contain any laboratory tests, specific to laboratory specimen results for the identified dates; RPN #105 indicated that there is no documentation indicating that the results of the laboratory testing were received.

Corporate Nurse Consultant contacted the laboratory during this inspection and obtained test results for specimens sent on the identified dates, for resident #002. Both laboratory tests directed to repeat culture if indicated.

The clinical health record, reviewed for the identified period, fails to provide supporting documentation that resident #002 was reassessed for continued need of the identified treatment, following the two week treatment period; a reassessment should have taken place on or before as specific date, as per the physician's order. Nor was there supporting documentation that registered nursing staff obtained or followed up laboratory test results, sent on the two identified dates.

The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences. [s. 6. (2)]

2. The licensee failed to comply with LTCHA, s. 6 (2), by not ensuring the plan of care is based on an assessment of the resident and the resident's needs and preferences.

Related to Intake #018334-16, for Resident #001:

Resident #001 has a cognitive impairment. Resident #001 has a known history of exhibiting specific responsive behaviours.

The clinical health record, for resident #001, was reviewed for the period of approximately seven months; the following was identified during this review:
- On a specified date, the physician ordered a specific medication, be decreased twice daily for one week, and then to have medication reassessed.
- The order for the identified medication was flagged by the pharmacy, within the electronic physician's orders for the medication to be reassessed seven days later.
- The medication administration record indicates that ordered medication was last administered on the seventh day. There is no documented record that the identified medication for resident #001 was reassessed.
- The identified medication, which was ordered for resident #001, was not listed as a medication being administered on the medication administration record during a period of three months.
- On an identified date, three months later, the physician ordered the medication dosage, to be increased twice daily.

Registered Practical Nurse #105, who is the Charge Nurse, for the resident home area, confirmed that a reassessment of the identified medication for resident #001 had not occurred as ordered, and hence the ordered medication had somehow dropped off of the prescribed orders for resident #001. Registered Practical Nurse #001 indicated that order to increase the medication three months later, on an identified date, should have been caught by registered nursing staff and the pharmacy.

Registered Practical Nurse #105 indicated " it is his/her belief, that going from not having any medication to the medication being administered twice daily may have been a contributing factor to resident #001 falling asleep during family visits."

The licensee failed to ensure the plan of care was based on the assessment of the resident and the needs and preferences of resident #001, as evidenced by the medication ordered for a specific date, for resident #001 should have been reassessed as ordered and that the order, for the increased medication, should have been clarified with the physician. [s. 6. (2)]

3. The licensee has failed to comply with LTCHA, 2007, s. 6 (5), by not ensuring the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM has been provide the opportunity to participate fully in the development and implementation of the plan of care.

Related to Intake #018334-16, for Resident #002:

Substitute Decision Maker #007 indicated being initially told that resident #002 would require a specific treatment for approximately two weeks. SDM indicated resident #002 has had the identified treatment for more than a month. Substitute Decision Maker #007 indicated that he/she contacted the Director of Care on an identified date and was told that treatment had been discontinued the week prior. Substitute Decision Maker #007 indicated, he/she was not notified of the discontinued treatment.

Resident #002 has a cognitive impairment. According to the clinical health record, resident #002's attending physician ordered a specific treatment to aide with healing. Substitute Decision Maker was notified of the new order and was in agreement. The identified treatment use was to be reassessed in two weeks.

The clinical health record, for resident #002, provides documentation of the following:
- A specific treatment was in place, as an ordered treatment measure during the period of approximately a month and a half.
- On an identified date, the attending physician for resident #002 ordered the treatment to be discontinued.

The clinical health record, reviewed for the period of approximately a month and a half, failed to provide supporting documentation that resident #002's substitute decision maker was notified of, a) the treatment being required beyond the initial two week treatment period; and b) that the treatment had been discontinued.

Registered Practical Nurse #105, who works as the charge nurse, for the resident home area where resident #002 resides, reviewed the clinical health record and acknowledged that there was no indication of substitute decision maker(s) for resident #002 having been notified of, a) that the treatment was required beyond the initial two weeks, nor b) when the treatment was discontinued. [s. 6. (5)]

4. The licensee failed to comply with LTCHA, s. 6 (5), by not ensuring the resident, the substitute decision maker (SDM), if any, and the designate of the resident/SDM has been

provided the opportunity to participate fully in the development and the implementation of the plan.

Related to Intake #018334-16, for Resident #001:

Resident #001 has a cognitive impairment. Resident #001 has a known history of exhibiting identified responsive behaviours.

Personal Support Workers, Registered Nursing Staff, and the Director of Care all indicated that resident #001 exited the long-term care home on a specific date, and was found down the street from the long-term care home. A Critical Incident Report was submitted to the Director specific to this incident.

Substitute Decision Maker #007 indicated that following the date of this incident, resident #001 has had increased episodes of falling asleep or being sleepy when family visit.

On a specific date, resident #001's attending physician ordered the following:
- increase a specific medication's dosage twice daily

Registered Practical Nurse (RPN) #105 contacted Substitute Decision Maker #025, who shares the SDM role with SDM #007, as to the medication changes. Substitute Decision Maker #025 indicated, to RPN #105, that he/she was not consenting to the increase of the medication, asked that the medication not be given and that the medication be discontinued.

According to the medication administration record, the medication was given twice daily over a two day period.

Registered Practical Nurse #105 confirmed speaking to SDM #025, and indicated being aware that SDM #025 not only did not want the increase dose of medication given, but SDM wanted the medication discontinued. RPN #105 indicated he/she had made a note on the physician's order sheet indicating that SDM had not consented to the medication being given to resident #001. RPN #105 indicated he/she had not contacted the physician on the identified date, following the conversation where the SDM was refusing consent for the medication and had requested the medication be discontinued.

The licensee failed to ensure that the resident, the substitute decision maker (SDM), if any, and the designate of the resident/SDM had been provided the opportunity to

participate fully in the development and the implementation of the plan of care, as evidenced by, registered nursing staff did not contact or communicate with resident #001's physician following the discussion with substitute decision maker on the identified date regarding the identified medication. [s. 6. (5)]

5. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care provided to the resident as specified in the plan.

Related to Intake #016632-16, and #018824-16, for Resident #003:

Substitute Decision Maker (SDM) #006 indicated that family visited resident #003 on a identified date and found resident sitting in his/her mobility aide, SDM #006 indicated that resident was uncomfortable and had not had his/her continence care provided.

Substitute Decision Maker brought this concern to the Director of Care (DOC); Director of Care responded to the SDM "this incident should not have happened and will not happen again".

The Director Care indicated, to the inspector, that the home was short staffed on the identified date. DOC indicated that resident was not provided care, specifically toileting, incontinence care and rest/sleep routine, as per the plan of care on this same date.

The plan of care for resident #003 details the following:

- resident has physical limitations, chronic discomfort and cognition impairment
- requires total assistance of one to two staff for activities of daily living
- total assistance, using a transferring device to transfer resident into and out of bed, and or mobility aid; resident is non-weight bearing
- two staff to provide resident continence care while resident is in bed
- altered skin integrity; treatment measures in place
- palliative care, comfort measures
- up for specific meals
- has identified discomfort; to be transferred into bed following a specific meal and remains in bed for other meal
- in bed following a specific meal, but does not settle to sleep until an identified hour

Substitute Decision Maker #006 indicated that resident #003 has chronic discomfort and is to be in bed following meals. Substitute Decision Maker #006 indicated that he/she has

voiced concerns on more than one occasion to the Director of Care, specific to staff not providing care to resident #003 as per the plan of care. Substitute Decision Maker #006 indicated being frustrated that care issues continue to occur. [s. 6. (7)]

6. Related to Intake #006472-16, Resident #011:

Resident #011 was identified as being at risk of falls due to his/her medical conditions and falls he/she has sustained between a six month period. Among the interventions to prevent further falls, the resident's current plan of care included instructions to have a personal safety device clipped securely to the resident at all times.

On an identified date and time, resident #011 was observed to be in bed sleeping with the personal safety device found on the TV stand in the resident's room and not attached to the resident.

Personal Support Worker #113, Registered Nurse #100, the Director of Care and the Administrator, all acknowledged that the personal safety device should be attached to the resident at all times. With regards to this fall prevention intervention, all confirmed that the care was not provided as specified in resident # 011's plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring the plan of care was based on an assessment of the resident and the resident's needs and preferences; the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM has been provide the opportunity to participate fully in the development and implementation of the plan of care; and the care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 19. Generators

Specifically failed to comply with the following:

s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 19 (4), by not ensuring that, on May 30, 2016, a generator that can maintain the heating system, emergency lighting, and all essential services, was operational within 3 hours of a power outage.

Ballycliffe Lodge has Class C beds within the meaning of the Act, subsection 187 (18).

Under O. Reg. 79/10, s. 19 (1), every licensee of a long-term care home shall ensure that the home is served by a generator that is available at all times and that has the capacity to maintain, in the event of a power outage, a) the heating system; b) emergency lighting in hallways, corridors, stairways and exits; and c) essential services, including dietary services equipment required to store food at a safe temperature and prepare and deliver meals and snacks, the resident-staff communication and response system, elevator and life support, safety and emergency equipment.

Related to Intake #016632-16:

Registered Nurse-Supervisor #124, who was working the evening shift on an identified date, indicated that the long-term care home had a power outage and had lost power at approximately 19:00 hours. RN #124 indicated he/she was not exactly sure of the time, and commented that the power loss could have been started earlier than 19:00 hours. RN #124 indicated that he/she placed a call to the Environmental Services Manager and the Administrator at approximately 19:15 hours on the said date.

Registered Nurse #124 indicated that residents who resided on specific floors of the home were unable to return to their assigned rooms, as the elevators in the home were not in service during the power outage.

The Administrator acknowledged that the long-term care home did experience a power

outage on the identified date. The Administrator provided the inspector with a copy of the Critical Incident Report (CIR) which was submitted to the Director approximately a week later. The Ministry of Health and Long-Term Care was notified of the power outage on actual date of the occurrence, using the after-hours contact number.

The Environmental Services Manager (ESM) indicated that the home is equipped with two on-site generators, which were operational during the power outage; ESM indicated that the two on-site generators do not power the entire heating system nor did the on-site generators power all essential services in the long-term care home.

The Environmental Services Manager indicated that on the said date, there was no power to the following:
- elevators (required service)
- resident-staff communication and response system
- door alarm safety system
- dietary services equipment, specifically the stand-up refrigeration unit
- fan coils in resident rooms (supplies heat), circulating heat pump, make up air units (HVAC)

The Administrator indicated that the home has verbal agreements with two companies to supply the long-term care home with a temporary generator. Administrator indicated calling both companies, on the said date. Administrator indicated that her calls were placed at approximately 19:15 hours. The Administrator indicated that one of the companies returned her call and confirmed that they would supply the long-term care home with a generator.

The Administrator and the Environmental Services Manager indicated that power was restored to the long-term care home at approximately 22:40 hours, at which time the service provider for the generator was contacted and the order for a generator was cancelled; as of this time, the generator which was ordered had not yet arrived at the long-term care home.

During an interview, a representative from the service company (for the generator) indicated, to the inspector, that the Administrator of Ballycliffe Lodge contacted them approximately one hour and forty-six minutes after the power outage began, and requested a generator due to a power outage. The representative from the service company indicated receipt of second call from Ballycliffe Lodge indicating that they no longer required the generator as the power to the long-term care home had been

restored. The service company representative, indicated at the time of the second call, the generator had not yet left the yard of the generator supply company, as they were waiting on a truck to transport the generator.

Administrator indicated being unable to comment on why the generator was not on-site and operational within the three hour requirement.

The licensee has not ensured that the home has access to a generator that is operational within three hours of a power outage and that can maintain power to everything required under O. Reg. 79/10, s. 19 (1), which poses risk to the health, safety, comfort and well-being of residents when a prolonged power outage occurs. [s. 19. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place to ensure the home has access to a generator that will be operational within three hours of a power outage and that it can maintain the heating, system, emergency lighting in the hallways, corridors, stairways and exits and essential services, as required under section 19 (1) (a), (b) and (c), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 22 (1), by not ensuring that written complaints received regarding care of a resident or the operations of the home were immediately forwarded to the Director.

Related to Intake #016632-16, related to Resident #003:

Substitute Decision Maker (SDM) #006 indicated having concerns regarding the care of resident #003 and the operations of the long-term care home, specifically shortage of staff, during evenings and weekends. Substitute Decision Maker indicated that he/she had sent concerns, via written correspondence to the Director of Care.

Details of the written correspondence, by SDM #006, are as follows:

- On an identified date – Substitute Decision Maker #006 indicated family visited resident #003 three days earlier and found resident sitting in a mobility aid. Substitute Decision Maker #006 indicated in his/her written correspondence that resident was to be in bed following a specific meal as per plan of care. SDM #006 further alleged "that resident was uncomfortable and that care, for resident #003 had not been provided, for twelve hours, due to long-term care home being short staffed. Substitute Decision Maker #006 indicated that the incident was “totally unacceptable”. SDM #006 requested explanation from the Director of Care as to how such happened.

- On a separate date– Substitute Decision Maker #006 indicated that "he/she and his/her family visited resident #003 during the evening of a specified date and found resident #003 almost out of his/her mobility aide". SDM #006 indicated the position of the resident was not only unsafe, but uncomfortable for the resident. SDM #006 indicated not being able to locate any staff, and that he/she and his/her family lifted resident #003 from mobility aid into bed. Substitute Decision Maker requested “that resident’s plan of care be yet again reviewed with staff and for DOC to advise if there is a shortage of staff”.

The Director of Care acknowledged that she received written correspondence (emails) on the identified dates, from Substitute Decision Maker (SDM) #006, regarding the care of resident #003.

The Director of Care acknowledged receipt of the above written correspondence from Substitute Decision Maker. Director of Care acknowledge that the written correspondence related to care of resident #003, as well as the operations of the long-term care home, specifically staffing. The Director of Care indicated that the written correspondence would be seen as complaints from Substitute Decision Maker #006.

The Director of Care, indicated that the written correspondence, received via email were not forwarded to the Director. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place to ensure that written complaints received regarding care of a resident or the operations of the home were immediately forwarded to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 101 (2), by not ensuring that a documented record, of complaints, is kept in the home and includes, the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of action, time frames for actions to be taken and any follow-up required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any responses made by the complainant.

The home's Complaint Log Workbook was provided to the inspector by the Administrator. The Complaint Log Workbook was reviewed for the period of approximately six months.

The Complaint Log Workbook failed to provide consistent documentation of the following:

- the nature of each verbal and written complaint
- dates actions taken
- time frames for actions to be taken
- dates response was provided to the complainant
- any responses made by the complainant

The Administrator was in agreement that the Complaint Log Workbook details was not consistent with legislative requirements.

2) Related to Intake #016632-16, related to Resident #003:

Substitute Decision Maker #006 sent a written correspondence (email) to the Director of Care, on an identified date, regarding care concerns and staffing, specific to an incident which was said to occur three days earlier.

This written concern was not documented in the Complaint Log Workbook.

The Administrator indicated not being made aware of Substitute Decision Maker #006's concern; the Administrator indicated that the Director of Care was aware of the concerns of SDM #006, and thus, the complaint should have been documented in the Complaints Log Workbook. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place ensuring that a documented record, of complaints, is kept in the home and includes, the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of action, time frames for actions to be taken and any follow-up required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any responses made by the complainant, to be implemented voluntarily.

Issued on this 12th day of August, 2016

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

Original report signed by the inspector.