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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: March 15, 2023

Inspection Number: 2023-1127-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.

Long Term Care Home and City: Niagara Long Term Care Residence, Niagara-on-the-Lake

Lead Inspector	**Inspector Digital Signature**
Stephanie Smith (740738)	Stephanie D Smith Digitally signed by Stephanie D Smith Date: 2023.03.20 09:48:50 -04'00'

Additional Inspector(s)
Cathy Fediash (214)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 24, 27-28, March 1-3, and 6, 2023

The following intake(s) were inspected:

- Intake: #00002822 - Complaint regarding alleged abuse of resident
- Intake: #00008269 - Complaint regarding home's refusal to readmit from leave
- Intake: #00014369 - Fall of resident
- Intake: #00015436 - Fall of resident

The following intakes were completed in this inspection: Intake: #00001580, Intake: #00003030, Intake: #00004818, Intake: #00007077, Intake: #00015258, Intake: #00015633, were related to falls prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

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) (a)

The licensee has failed to ensure that a written plan of care that set out the planned care for a resident regarding specified care, had been in place.

Rationale and Summary
The home investigated a complaint of alleged abuse to a resident, by a staff member, that was indicated to have occurred on a date in June 2022. The home concluded the investigation in July 2022 and determined the resident's rights had not been upheld.

Interviews during the investigation confirmed the resident had a specified care issue.

An interview with the Director of Care (DOC), indicated the resident had a specified care issue. The resident's clinical record indicated they were admitted in the year 2017.

Review of progress notes, prior to this allegation, indicated the specified care issue on other dates in May and June, 2022.

Review of the resident's plan of care document indicated a focus statement, goals and interventions that set out the planned care for their specified care issue, was created on a day in July 2022, seven days following the conclusion of the home's investigation.

An interview with the DOC confirmed no planned care for the resident's specified care issue had been in place, until seven days following the conclusion of the investigation.

When there is no plan in place to identify the specified care needs of a resident, this has the potential

for staff to provide inconsistent care and could result in a risk of harm to the resident.

Sources: Resident's plan of care including care plan, progress notes; the home's investigative notes, and interviews with the DOC and other staff. [214]

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (d)

The licensee has failed to ensure that before discharging a resident under O. Reg 246/22, s. 157 (1), they provided a written notice to the resident, 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.

Rationale and Summary
A resident was discharged from the home in October 2022, as the resident's requirements for care had changed and the home could not provide a sufficiently secure environment. The resident's clinical records did not contain documentation of the written notice provided to the resident, that set out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care, that justified the home's decision to discharge the resident.

The DOC stated that the home mailed a discharge letter to the resident via regular mail service, however, was unable to provide a copy of the letter, nor a postal receipt. The DOC acknowledged that the home was unable to confirm that the written notice was provided to the resident. The resident's guardian acknowledged they did not receive a discharge letter addressed to the resident and that they would have if one had been sent.

Failure to ensure that the resident received a written notice of their discharge led to potential miscommunication to the resident.

Sources: Interview with DOC and the resident's guardian, resident's clinical records. [740738]