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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 28, 2024	
Inspection Number: 2024-1030-0002	
Inspection Type: Complaint	
Licensee: Dover Cliffs Operating Inc.	
Long Term Care Home and City: Dover Cliffs, Port Dover	
Lead Inspector Ali Nasser (523)	**Inspector Digital Signature** Ali Nasser Digitally signed by Ali Nasser Date: 2024.04.03 10:51:47 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 21, 25, 26, 2024

The following intake(s) were inspected:

- Intake: #00110734, complaint related to resident care concerns.
- Intake: #00111289, complaint related to resident care concerns.

Inspector Stephanie Newton (000820) was present during this inspection.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in the Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee failed to ensure that all doors leading to areas that residents do not have access to were kept closed and locked.

Rationale and Summary
Observations during the inspection showed a tub room door was opened and the tub room was unattended. There were several residents walking around the tub room. Inspector walked through the tub room where disinfectants were accessible to anyone who entered.

The Director of Care said the door should have been kept closed and locked when not in use.

There was a risk to the residents by having the tub room door opened and unattended with disinfectants accessible.

Sources: observations and interview [523]

WRITTEN NOTIFICATION: Care Plans

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (5)
24-hour admission care plan
s. 27 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker (SDM), if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan.

The licensee has failed to ensure that the resident's SDM was given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan.

Rational and Summary:
A complainant told the inspector they were the resident's SDM and they were not given an opportunity to participate in the development of the resident's care plan.

In an interview Assistant Director of Care (ADOC) said they locked the Move-in Assessment/24hr Care Plan for the resident. They confirmed they would've contacted the SDM for information to complete the assessment. The ADOC said interdisciplinary team members completed different sections of the assessment and they could have communicated with the SDM, but they did not find any documented evidence that the SDM was contacted at the time of admission to have various assessments completed to develop the care plan.

There was a risk to the resident by not having the SDM participate in the development of the resident's care plan.

Sources: record reviews and staff interviews. [523]