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
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London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: July 15, 2024
Inspection Number: 2024-1030-0004
Inspection Type: Complaint Critical Incident
Licensee: Dover Cliffs Operating Inc.
Long Term Care Home and City: Dover Cliffs, Port Dover

Lead Inspector	**Inspector Digital Signature**
Ali Nasser (523)	Ali Nasser Digitally signed by Ali Nasser Date: 2024.07.15 16:52:08 -04'00'

Additional Inspector(s)
Dante De Benedictis (000818)
Aby Thomas (000830)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3, 4, 8, 9, 2024

The following intake(s) were inspected:

- Intake: #00114318, Critical Incident related to improper/incompetent care of a resident.
- Intake: #00114750, Complaint related to alleged staff to resident neglect.
- Intake: #00114765, Complaint related to improper care of a resident.
- Intake: #00118753, Complaint related to resident's falls.

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

Continence Care
Resident Care and Support Services
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dignity and Proper Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to fully respect and promote a resident's right to proper care and services consistent with their needs.

Summary and Rationale:
The Ministry of Long-Term Care received a complaint related to resident care concerns. The complainant indicated that a resident received a treatment by an unqualified staff member and an inappropriate comment was made by this staff member to the resident. On a date an identified Personal Support Worker (PSW) provided a treatment to the resident that resulted in pain. The resident questioned if the PSW was qualified to provide the treatment and the PSW responded with an

inappropriate comment. A review of progress notes associated with the resident confirmed the treatment was completed by an unqualified PSW, the treatment was completed incorrectly and resulted in harm to the resident.

Interviews were completed with staff and the resident. The resident verified the incident had taken place. They felt as if they were not being treated with dignity and respect by the identified PSW based on their comment.

In interviews completed with the Administrator as well as a PSW and a Registered Nurse (RN) all acknowledged the treatment should only be applied by qualified staff which included nurses. Additionally, the Administrator acknowledged that the inappropriate comment was made by the staff member towards the resident.

Impact to the resident as a result of this incident involved a reduction in overall sense of dignity as well as a new injury which continues to cause discomfort.

Sources: record review, interviews. [000818]

WRITTEN NOTIFICATION: Reporting

NC #002 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.

Summary and Rationale:

A) On a date a treatment was applied to a resident improperly which resulted in an injury. A review of the progress notes associated with the resident confirmed the improper treatment and injury.

In an interview the resident acknowledged that the incident in question took place.

In an interview the Administrator acknowledged the incident took place and said they did not report the incident to the Director.

There is no evidence that this incident was reported to the Ministry of Long-Term Care.

Sources: record review/interviews. [000818]

B) On a date, an incident took place during a resident's transfer. Review of progress notes associated with the resident confirmed the incident and injury sustained as a result. There was no evidence found that this incident was reported to the MLTC.

In an interview the resident acknowledged that the incident in question took place.

In an interview the Administrator acknowledged the incident took plan and said they did not report the incident to the Director.

There is no evidence that this incident was reported to the Ministry of Long-Term Care.

Sources: record review, progress notes. [000818]

WRITTEN NOTIFICATION: Transferring Technique

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Summary and Rationale:

The Ministry of Long-Term Care received a Critical Incident Report as well two complaints regarding an incident that occurred during a resident's transfer where the PSW did not use safe transferring techniques.

Interviews with the resident and multiple staff members confirmed the PSW used improper and not safe transferring techniques.

During the incident in question, the resident sustained an injury as a result of the employment of an improper transferring technique.

Sources: record review, interviews. [000818]