Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 31, 2022
Inspection Number 2022_1560_0002
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Corporation of the County of Huron

Long-Term Care Home and City
Huronview Home for the Aged
Clinton ON

Lead Inspector
Cassandra Aleksic (689)

Inspector Digital Signature
Cassandra N Aleksic
Digitally signed by Cassandra N Aleksic
Date: 2022.08.31 15:58:55 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 23 & 24, 2022, and continued off-site on August 25, 29 & 30, 2022.

The following intake(s) were inspected:

Log # 014596-22 (Complaint) related to resident care and dealing with complaints

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

- Infection Prevention and Control (IPAC)
- Resident Care and Support Services

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INSPECTION RESULTS

WRITTEN NOTIFICATION [REPORTING CERTAIN MATTERS TO DIRECTOR]

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 [s. 28 (1) 1]

The licensee has failed to ensure that the information related to a suspected incident of incompetent care that resulted in a risk of harm to a resident was immediately reported to the Director.

Rationale and Summary
The Ministry of Long-Term Care Complaint Information Reports documented concerns regarding an allegation of incompetent care to a resident at Huronview Home for the Aged.

The complainant stated that the resident informed a staff member of concerns of wellbeing. The complainant stated that the staff member allegedly provided advice to the resident not within their scope of practice.

The Assistant Director of Care (ADOC) stated they were made aware of the allegations and initiated an investigation based on the risk of harm and safety for the resident. The ADOC stated that allegations of incompetent care resulting in a risk of harm to a resident should be reported immediately to the Director as per mandatory reporting requirements.

There was no Ministry of Long-Term Care Critical Incident Report completed by the home specific to the allegations of incompetent care by a staff member towards the resident.

Sources: Complaint information reports, interview with complainant, interview with ADOC, policies and procedures and review of the MLTC critical incident reporting website.

[689]