Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District

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

Original Public Report

Report Issue Date: April 28, 2023
Inspection Number: 2023-1167-0003
Inspection Type: Complaint Critical Incident System
Licensee: Maryban Holdings Ltd.
Long Term Care Home and City: Oakwood Park Lodge, Niagara Falls

Lead Inspector	**Inspector Digital Signature**
Klarizze Rozal (740765)	Klarizze Mae S Rozal Digitally signed by Klarizze Mae S Rozal Date: 2023.05.26 13:47:40 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 12-14, 2023, April 17-21, 2023

The following intake(s) were inspected:

- Intake: #00006597- for a Critical Incident (CI) related to resident to resident physical abuse.
- Intake: #00011226- for a Critical Incident related to resident to resident physical abuse.
- Intake: #00013175- for a Critical Incident related to a resident injury and transfer to hospital.
- Intake: #00017982- for a Complaint related to resident care concerns, staffing, assessments, and transfer to hospital.

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

Continence Care
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

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 (9) 1.

The licensee failed to ensure that a resident's provision of care set out in their plan of care was documented.

Rationale and Summary

A resident's Point of Care (POC) records in January 2023 indicated missing documentation for multiple care tasks on eight different dates and shifts.

The Assistant Director of Care (ADOC) and Director of Care (DOC) started POC audits to ensure staff documentation was completed.

The home's Documentation Policy stated that the expectation of Personal Support Workers (PSW) was to complete POC for each resident on each shift.

The failure to document the provision of care may have resulted in care not being provided as per a resident's plan of care.

Sources: Resident POC records, Documentation Policy, interviews with ADOC, DOC, and staff.

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COMPLIANCE ORDER CO #001 Duty to Protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:

1. Review and revise the plan of care for a specified resident to ensure that strategies are in place that minimize the risk of altercations with another resident.

2. Review and revise the plan of care for another specified resident to ensure that strategies are in place that minimize the risk of altercations with other residents.

Grounds

O.Reg. 246/22 s. 2 (1) (c) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A) The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Rationale and Summary

On a date in October 2022, a resident and another resident had a physical altercation.

The same residents had a prior altercation on a date in October 2022.

One resident sustained injuries.

Sources: CI report, resident electronic medical records, and interviews with staff.

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B) The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Rationale and Summary

On a date in June 2022, a resident had a physical altercation with another resident.

One resident sustained injuries.

Failure to protect residents from physical abuse by other residents resulted in physical injuries.

Sources: CI report, resident's electronic medical records, interviews with staff.

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This order must be complied with by May 11, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be

given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.