Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2019	2018_749722_0014	010789-17, 024670-17, 026358-17	Complaint

Licensee/Titulaire de permis

Trilogy LTC Inc.
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Trilogy Long Term Care Residence
340 McCowan Road SCARBOROUGH ON M1J 3P4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

COREY GREEN (722)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 27, 28, and 31, 2018; and January 2, 3, 4, 7, 8, and 9, 2019

During this inspection, the following intakes were inspected:

Log #024670-17 - Complaint involving provision of care, falls prevention, nutrition and hydration, medication administration, staffing, and allegation of neglect
Log #026358-17 - Complaint alleging neglect
Log #010789-17 - Critical incident involving allegation of abuse

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6(7) was identified in this inspection and has been issued in Inspection Report 2018_749722_0012, dated January 30, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), the Nutrition Manager, the Behavioural Support Ontario (BSO) nurse, registered nurses (RNs), registered practical nurses (RPNs), physiotherapy assistants (PTAs), personal support workers (PSWs), a unit clerk, residents, and resident family members.

During the inspection, the inspector made observations of residents, resident care, and resident home areas; reviewed licensee administrative records, including policies and procedures, complaint logs and documentation, staffing schedules, call bell response times, and investigation notes related to allegations of abuse/neglect; and reviewed resident health records (electronic and paper).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Related to log #010789-17

A critical incident report was submitted to the Director on a specified date, related to an allegation of abuse by an identified person involving a specified staff member, within a specified period of time. The identified person made specified allegations about inappropriate care by staff during an identified transfer of resident #005.

On a specified date, Inspector #722 reviewed a letter with a specified date that was provided by an identified person to the licensee during the licensee's investigation into the allegation of inappropriate care by staff during the transfer of resident #005. The letter described in detail a transfer of resident #005, on an unspecified date within a few days of admission to the home. According to the letter, resident #005 was transferred by the identified person and a specified staff member, without the use of devices for safe transferring.

A written letter provided by the staff member during the licensee's investigation of this incident was reviewed by Inspector #722 on a specified date, which was signed and dated on a specified date. In the letter, the staff member indicated that the identified person suggested that resident #005 be transferred, offered to show the staff how to transfer the resident, and proceeded with the transfer. The staff member indicated in the letter that the transfer was a challenge, that they notified the identified person that they can not do transfers like that in the home, and that a specified number of staff would be needed with appropriate transfer equipment.

Inspector #722 reviewed the care plan for resident #005 that was initiated on admission to the home, which indicated that the resident required assistance with transfers by a specified number of staff and using specific transfer equipment.

On a specified date, Inspector #722 reviewed assessments for resident #005 related to transferring. Specified assessments that were completed on the specified admission date indicated that the resident was unable to transfer independently due to specified reasons, required a specified level of assistance by a specified number of staff, and that specified equipment must be used to assist in the transfer.

The identified staff member was interviewed by Inspector #722 by telephone on a specified date and time, who indicated that they had worked in the home for a specified number of years, and have provided care to resident #005. The identified staff member verified writing the letter that was signed and dated on a specified date, as described above, and provided to the home during the investigation into the allegation of inappropriate care by the identified person. The staff member also confirmed during the telephone interview that they were not familiar with the transfer method required for resident #005 at the time of the incident, because the resident was a recent admission at that time.

During the interview, the identified staff member indicated that the identified person demonstrated to them how to transfer the resident. They indicated that after the identified person had completed part of the transfer, they assisted them to complete the transfer. The staff member indicated that they told the identified person that they can not transfer the resident like that in the home, that they will need to get physiotherapy to assess the resident, and they will have to use a specified transfer device because staff can not be lifting residents. The identified staff member acknowledged that they did not transfer resident #005 as per their plan of care during this incident, and indicated that they should have consulted with the RPN on shift to determine how to appropriately transfer the resident.

Another identified staff member was interviewed by Inspector #722 on a specified date, and indicated that they have worked in the home for a specified number of years, and have provided care to resident #005. The staff member indicated that resident #005 was always transferred with a specified number of staff using specified transfer equipment, and indicated that was what was in the resident's care plan. The identified staff member also indicated that resident #005 had always required the same level of assistance for transfers since being admitted to the home. The staff also indicated that they knew how to transfer the resident because there was a sign above the bed that indicated that they required a specified device for transfers.

Inspector #722 interviewed the Assistant Director of Care (ADOC) #106 on a specified date, who indicated that residents in the home have a sign with a logo posted above their bed that indicated what kind of a transfer they were (e.g., independent, one-person assist, two-person assist, mechanical lift, etc.). The ADOC indicated that if the sign was not yet posted above the resident's bed at the time of the transfer, that direct care staff should get direction from the RPN to determine how to transfer a resident.

The ADOC also indicated that only staff in the home should be transferring residents; and that resident's visitors who are not staff in the home should not be providing the assistance for transfers as specified in the care plan while the resident is in the home. ADOC #106 confirmed that resident #005 has required a specified level of assistance for transfers since admission to the home. The ADOC also confirmed that it was not appropriate for resident #005 to be transferred without the appropriate number of staff and specified devices as per the resident's plan of care, and that residents should only be transferred by staff in the home.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when resident #005 was transferred within a specified period after admission by an identified person, with assistance by an identified staff member, and without using appropriate transfer techniques as specified in the resident's written plan of care. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

Related to log #024670-17

A complaint was received by resident #004's substitute decision maker (SDM) through the MOHLTC Action Line on a specified date. The SDM indicated in the complaint that staff were not providing resident #004 with appropriate levels of assistance during meals. During observation of a meal service, Inspector #722 identified that resident #004 was not offered or provided the main course.

On a specified date and time, Inspector #722 reviewed the daily menu posted outside the dining room in the specified resident home area (RHA), which indicated a specified appetizer, two specified main course options, and two specified choices for dessert. Inspector #722 reviewed resident #004's current care plan on a specified date, related to food and nutrition, which specified the resident's diet requirements, food preferences, directions related to assistance at meal times, and other specified nutritional requirements.

On a specified date, Inspector #722 observed resident #004 during a specified meal service in a specified RHA. Prior to the meal service commencing, the resident had been placed in a specified RHA outside the dining room. For a specified period at the beginning of the meal service, RPN #120 provided a cup to the resident containing liquid, and then left. RPN #120 returned on a specified number of occasions to determine if resident #005 had consumed the contents of the cup. When the resident finished consuming the contents of the cup, RPN #120 took the cup from the resident and walked away.

Over a specified period of time, while residents were being served their meal in the dining room, resident #004 remained in the specified RHA. Towards the end of the meal service, PSW #121 was observed assisting the resident with another cup containing fluid; the PSW indicated to Inspector #722 that the cup contained a beverage from the daily menu, as well as a specified nutritional item specified in the resident's written plan of care. The PSW stepped away and returned, and indicated to Inspector #722 that they added one of the dessert food choices to the cup, mixed with the previous items. The PSW provided the resident with a specified level of assistance to consume the contents of the cup. At a later specified time, the doors to the dining room were closed, and the resident was not provided with any other food or fluids.

On the same date the meal service was observed, Inspector #722 interviewed RPN #120 at a specified time concerning the specified meal service for resident #004. During the interview, RPN #120 indicated that at the beginning of the meal service, they had provided the resident with a nutritional supplement. RPN #120 indicated that they had only provided the nutritional supplement, and confirmed that they did not provide the resident with any items from the menu for the specified meal service on the specified date.

On the same date the meal service was observed, Inspector #722 interviewed PSW #121 related to resident #004's specified meal service. The PSW confirmed that they were responsible for providing resident #004 with assistance during the meal service. PSW #121 indicated they had provided assistance to resident #004 to consume the contents of the cup as observed by Inspector #722, confirmed that the cup initially contained a beverage item from the daily menu, and an additional food item that was part of the resident's nutritional plan of care. The PSW indicated that they then added one of the dessert items from the daily menu for the specified meal service. During the interview, PSW #121 confirmed that they had not provided resident #004 with the appetizer, or either of the main course choices during the meal service. PSW #121 also confirmed that they had not provided resident #004 with any additional food or beverages during the specified meal service on the specified date.

Inspector #722 interviewed the Nutrition Manager at a specified time on the date the specified meal service was observed for resident #004. During the interview, the Nutrition Manager indicated that the specified menu on the specified date included a specified appetizer, two specified main course choices, and a choice of two dessert items. The Nutrition Manager indicated that the expectation is that all residents will be offered and provided food on the daily menu, including choices for the main course and dessert, and according to their therapeutic interventions.

The Assistant Director of Care (ADOC #106) was interviewed by Inspector #722 at a specified time on the specified date that the meal service was observed for resident #004. ADOC #106 confirmed that resident #004 should have been offered and provided the daily food options and beverages as per the posted menu items, and that resident #004 should have received one of the main course options.

The licensee failed to ensure that the planned menu items were offered and available at each meal and snack, when resident #004 was not provided with the planned appetizer

and either main course option during the observed meal service on a specified date. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items are offered and available to residents at each meal and snack, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

Related to log #026358-17

A complaint was received by an identified staff member through the MOHLTC Action Line on a specified date, related to concerns about the care provided to residents in the home. In the complaint, the staff member indicated that appropriate care had not been provided to specified residents by specified staff, and that they have written letters to the licensee related to their concerns.

Inspector #722 reviewed the home's investigation notes related to the complaint by the staff member, that were provided by the DOC on a specified date. The file included a letter from the staff member with a specified date, which indicated concerns related to resident care and safety involving several residents, specifically resident #005, and

specified staff.

The opening of the letter by the staff member submitted on a specified date, indicated that this was the second written notification of concerns. When requested by Inspector #722, the staff member and the licensee were unable to locate and/or provide an earlier letter of complaint from the staff member.

On a specified date, Inspector #722 interviewed the staff member, who indicated that they have worked in the home for a specified number of years. During the interview, the staff member confirmed that they submitted the letter to the DOC of the home on the specified date indicated on the letter, and confirmed that they had raised a number of concerns about the care provided by staff to residents on a specified resident home area (RHA).

On a specified date, Inspector #722 reviewed meeting notes by the Administrator and DOC for meetings with the identified staff member on specified dates. The meeting notes by both the Administrator and DOC on a specified date, made reference to the letter received on an earlier specified date. The meeting notes indicated that the meetings were related to the various concerns that were raised in the letter by the staff member, about resident care provided by specified staff.

The DOC was interviewed by Inspector #722 on a specified date, who acknowledged receiving the letter of complaint from the staff member on or around the specified date indicated on the letter, but could not recall the exact date the letter was received. The DOC confirmed that the identified staff member had made complaints about residents under the care of identified staff, specifically resident #005. The DOC confirmed that the licensee's usual process for managing complaints about resident care were not followed in this instance, and that the letter was not forward to the Director as required under the legislation.

The licensee failed to ensure that when the Administrator and DOC received the written letter of complaint from a staff member on or around a specified date, concerning the care of a resident, that it was immediately forwarded to the Director. [s. 22. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.

Related to log #024670-17

A complaint was received by resident #004's SDM through the Ministry of Health and Long-Term Care (MOHLTC) Action Line on a specified date, related to concerns that resident #004 was not receiving adequate assistance with nutrition and hydration.

On a specified date, Inspector #722 observed resident #004 during a specified meal service in a specified RHA. Prior to the meal service, Inspector #722 observed that the resident had been placed in a specified location in the RHA that was outside the dining room. Resident #005 required a specified level of assistance to mobilize in the home.

Over a specified period of time, while residents were being served their meal in the dining room, resident #004 remained in the specified RHA outside the dining room. At the beginning of the meal service, RPN #120 provided the resident with a cup of fluid to drink while they were located outside the dining room; the cup was taken away by the RPN when it was empty. Towards the end of the meal service, PSW #121 provided specified assistance to resident #005 to consume specified portions of their meal while located outside the dining room. At a later specified time, the doors to the dining room were closed, and resident #005 was never taken into the dining room. Throughout the dining service, resident #005 did not exhibit specified behaviours.

Resident #004's current written care plan was reviewed by Inspector #722, which indicated that the resident can eat in the dining room when they are calm, but staff were to move the resident to a specified RHA to eat their meal when exhibiting specified behaviours. The RHA specified in the care plan was different than the RHA where the

resident was initially positioned prior to the meal service, and where they were located throughout the observed meal service.

Inspector #722 interviewed PSW #121 on a specified date and time, who confirmed that they had fed the resident in the specified RHA during the observed meal service, and that the resident had not been taken into the dining room for the meal service. The PSW indicated that the expectation was that the resident should have been taken into the dining room for the meal service, and if the resident exhibited specified behaviours, that the resident could be taken out of the dining room for their meal and placed in another specified RHA. PSW #121 confirmed that the resident was not exhibiting specified behaviours, and should have been taken into the dining room for their lunch service on the specified date.

Inspector #722 interviewed the Nutrition Manager on a specified date and time, related to the meal service in the dining room on the specified RHA. During the interview, the Nutrition Manager indicated that the expectation was that all residents were to be provided their meal service in the dining room. The Nutrition Manager indicated that when resident #004 exhibits specified behaviours, they are taken out of the dining room during the meal service. The Nutrition Manager indicated that the staff were placing the resident in a specified RHA (different than indicated in the care plan) during meals when the resident exhibited specified behaviours. During the interview, the Nutrition Manager confirmed that resident #004 was not taken into the dining room for the lunch meal service on this occasion, and that the resident was not exhibiting specified behaviours.

The Assistant Director of Care (ADOC #106) was interviewed by Inspector #722 on on a specified date and time, related to resident #004's meal service on this day. The ADOC confirmed that the expectation was that resident #004 was to be provided meals in the dining room with other residents, and that the resident should only be moved to a specified RHA outside the dining room when they exhibit specified behaviours.

The licensee has failed to ensure that the home had a dining and snack service that included meal service in a congregate dining setting, unless a resident's assessed needs indicated otherwise, when resident #001 was not taken into the dining room for the specified meal service on a specified date. [s. 73. (1) 3.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Related to log #024670-17

A complaint was received by resident #004's SDM through the MOHLTC Action Line on a specified date. The SDM identified the following concerns related to resident #004's care:
- A specified number of falls within a specified period of time, including a fall with injury
- Post fall care, assessments, and interventions were not provided

- Call bell was activated and no staff responded
- Staff not assisting resident #004 with eating and drinking
- Medications not being administered at the appropriate times

Resident #004 was admitted to the home on a specified date, and this complaint related to concerns with care during the first specified period of time after resident #004's admission to the home.

Inspector #722 interviewed resident #004's SDM by telephone on a specified date, prior to conducting the inspection. The SDM indicated that they had provided all their notes related to their complaints about resident #004's care to the DOC around the same time that they made their call to the MOHLTC. The SDM indicated that they had several meetings with the Administrator and DOC to find out what they wanted, and that they were supposed to provide some letter in writing. The SDM indicated that they have never received a written response from the home related to their concerns.

On a specified date, Inspector #722 reviewed the progress notes for resident #004. On a specified date and time, RPN #123 entered a progress note that indicated that the SDM approached the RPN at the nursing station at a specified time and expressed concerns related to the resident's care. The progress note by RPN #123 also indicated that the SDM notified the RPN that they had notes about the resident's care since arriving at the home, and that the resident's first fall could have been avoided.

Inspector #722 interviewed RPN #123 on a specified date and time, who was working on the floor where resident #004 resided at the time of admission. During the interview, RPN #123 indicated that, although they did not recall the particulars, they remember that the resident's SDM had concerns about the care that resident #004 received in the home. RPN #123 confirmed that the SDM had concerns about the care the resident had received. RPN #123 indicated that when they received the complaints, that they notified Assistant Director of Care (ADOC) #106.

Inspector #722 reviewed the licensee's complaint log and binder on a specified date, for a specified period, and was unable to locate any record of a complaint related to resident #004. There was also no Concern Communication Form completed for a complaint that involved resident #004, and/or complaint investigation notes.

On a specified date, Inspector #722 interviewed the DOC, who indicated that according to the licencee's policy, the complaint received by RPN #123 from resident #004's SDM

on the specified date, should have been listed in the complaint log; a Concern Communication Form should have been completed that indicated the date and time of the complaint; as well as the resident's name and room number, the name of the person expressing the concern, the person receiving the concern, the topic of the concern with details, investigation notes, description of the resolution, and date of resolution with person expressing concern. The DOC indicated that the investigation notes may be kept separately from the complaints binder, but confirmed that that there were no investigation notes related to the complaint received from resident #004's SDM during a specified period of time.

During the interview, the DOC indicated that they were not notified that resident #005's SDM had made a complaint about the resident's care to staff on a specified date, and confirmed that the home should have initiated an investigation when the SDM brought these concerns to RPN #123. During the interview, the DOC confirmed they were not informed of the complaint made and documented in the progress notes on the specified date, that no investigation was initiated at that time in response to the complaint, and no formal response, either verbally or in writing, was provided to the SDM. The DOC confirmed that the complaint received by resident #004's SDM was not addressed as per the home's complaint policy and/or according to the legislation.

The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, when the licensee did not investigate and/or provide a response to resident #004's SDM after they made a verbal complaint to RPN #123 on a specified date. [s. 101. (1) 1.]

2. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, that a response was made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief?

Related to log #026358-17

A complaint was received by a staff member through the MOHLTC Action Line on a specified date, related to concerns about the care provided by staff to residents in the

home. In the complaint, the identified staff member indicated that they have previously notified the Administrator and DOC of their concerns, and that they have submitted letters related to these concerns.

On a specified date, Inspector #722 interviewed the identified staff member, who indicated that they have worked in the home for a specified number of years. The staff member indicated that they have reported concerns to the home's Administrator and DOC "many times" related to care provided by specified staff, specifically concerning residents #006 and #007.

Inspector #722 reviewed the home's investigation notes related to the complaint by the staff member. The file included a letter written by the staff member with a specified date, which indicated that this was the second letter of complaint provided to management regarding resident care and identified staff. The letter identified concerns related to inappropriate resident care, specifically involving resident #005 and identified staff.

On a specified date, Inspector #722 reviewed meeting notes by the Administrator and DOC for meetings with the staff member on specified dates, related to concerns about care provided by identified staff. The DOC indicated to Inspector #722 during an interview on a specified date, that these notes constituted the investigation notes related to the staff member's complaints. The meeting notes reviewed were largely information gathering notes and human resource discussions. Inspector #722 was unable to identify any information in any of the meeting notes that described a response to the specified staff member related to the allegations of inappropriate resident care involving specified residents and staff.

The licensee's complaint log and binder for a specified period was reviewed by Inspector #722 on a specified date, and there were no additional documents identified relating to concerns with care provided by specified staff to residents #005, #006, and/or #007. The DOC confirmed in the interview with Inspector #722 on a specified date that the investigation notes provided to the inspector from the human resource files for the identified staff were the only documents available related to the staff member's complaints.

During the interview with Inspector #722 on a specified date, the specified staff member indicated that they have never received a response from the management of the home, either verbally or in writing, related to their complaint about the care provided by specified staff to various residents in the home that indicated what was done to resolve the

complaint and/or that the licensee believed the complaint to be unfounded and the reason for the belief.

The DOC was interviewed by Inspector #722 on a specified date, who acknowledged that the specified staff member had made complaints about the care provided by staff, and recalled concerns raised in an earlier specified period of time. The DOC indicated that they became aware that the staff member had concerns about resident care involving identified staff at a specified period of time. The DOC indicated that the first formal complaint they received was the letter with a specified date, which the DOC believed was the first letter that the staff member submitted to management. Although the letter of complaint indicated that it was the second letter provided to management, the staff member and the DOC were unable to provide a copy of any other written letters of complaint related to concerns about resident care and identified staff.

The DOC acknowledged that they were aware of the resident care issues raised by the staff member, and that upon investigation of the complaints, most of the allegations were unfounded. The DOC confirmed that the licensee did not provide the identified staff member with any responses, verbally or in writing, related to the specified concerns involving inappropriate resident care and identified staff.

The licensee failed to ensure that when the identified staff member made complaints to the Administrator and DOC concerning the care provided to a number of residents in the home, specifically involving identified staff, that a response was made to the staff member, indicating: i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. [s. 101. (1) 3.]

Issued on this 4th day of February, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.