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

Ottawa District
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Original Public Report

Report Issue Date: October 13, 2023	
Inspection Number: 2023-1460-0003	
Inspection Type: Complaint Critical Incident	
Licensee: AON Inc.	
Long Term Care Home and City: Moira Place Long-Term Care Home, Tweed	
Lead Inspector Wendy Brown (602)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 4, 5, 6, 10, 11, 2023

The following intake(s) were inspected:

- Intake: #00090824 - Complaint regarding the alleged inappropriate discharge of a resident.
- Intake: #00088296 - Complaint regarding insufficient staffing impacting resident care.
- Intake: #00097175/ CIS #2977-000006-23, #00097643/ CIS #2977-000008-23 and #00097798/ CIS #2977-000009-23- regarding fall(s) with injury and transfer to hospital.

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

Infection Prevention and Control
Staffing, Training and Care Standards
Falls Prevention and Management
Admission, Absences and Discharge

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 (1) (c)

The licensee failed to ensure that a resident plan of care set out clear direction to staff and others who provide direct care to the resident.

Rationale & Summary:
A resident had an unwitnessed fall. They were transferred to hospital where a fracture was repaired after which they returned to the home. A review of the care plan and multiple observations at the time of inspection found conflicting information regarding transfer and mobility status. The written care plan and the in-room transfer logo indicated the resident required assistance of one to stand/transfer and also that the resident required a mechanical lift to transfer. The daily assignment worksheet, used by direct care staff, indicated the resident was using a walker and required minimal supervision of one staff. Interviews and observations indicated resident was now in bed only. Unclear direction could place the resident at an increased risk for falls.

Sources:
Critical Incident System (CIS) report, progress notes, current care plan, multiple observations and interviews with the Director of Care (DOC), a Registered Practical Nurse (RPN) and a Personal Support Worker (PSW). [602]

WRITTEN NOTIFICATION: Discharge

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (b)

The licensee failed to ensure they collaborated with the appropriate placement coordinator and other health service organizations regarding alternative accommodations/care before discharging a resident.

Rational and Summary:
A resident was admitted in to the Long-Term Care home from hospital in significant distress. Staff were unable to provide the care required for the specific needs of the resident. The resident was transferred back to hospital and discharged from the home the following day. There was no communication with the Hospital or placement coordination services regarding alternative accommodation/care for the resident prior to discharge.

Sources:
Interviews with the Home and Community Care Support Services (HCCSS) Placement Manager and Placement Coordinator and the DOC.