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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: December 6, 2023	
Inspection Number: 2023-1139-0003	
Inspection Type: Complaint Critical Incident	
Licensee: Iris L.P., by its general partners, Iris GP Inc. and AgeCare Iris Management Ltd.	
Long Term Care Home and City: AgeCare Aurora, Aurora	
Lead Inspector Laura Crocker (741753)	**Inspector Digital Signature** Laura L Crocker Digitally signed by Laura L Crocker Date: 2023.12.19 11:28:54 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 31, 2023, and November 1, 2, 3, 6, 7, 8, 9, 10, 14, 2023

The following intake(s) were inspected:
Intake: #00087699- complaint related to neglect, and multiple care concerns.
Intake: #00095215 - complaint related to responsive behaviours.
Intake: #00096412 - CI #2630-000015-23 related to alleged staff to resident abuse.
Intake: #00098595 - CI #2630-000024-23 - related to responsive behaviours
Intake: #00098704 - CI# 2630-000026-23 - related to falls preventions and management

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

Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RIGHT TO BE TREATED WITH RESPECT

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 3.

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:

3. Every resident has the right to have their participation in decision-making respected.

The home has failed to ensure every resident has a right to have their participation in decision-making respected.

Rationale and Summary:

A CIR was submitted to the Director, reporting they had received a written concern from a PSW. The PSW indicated they overheard a co-worker raising their voice, shouting at a resident. The Director of Care (DOC) indicated the PSW would be removed from the resident's care.

Prior to the inspection, inspector spoke to the resident about their complaint. The resident was upset the PSW had provided them care.

The resident 's clinical records, confirmed care was provided to the resident by the PSW. The ADOC further confirmed the documentation in the resident's clinical records was by the PSW. The ADOC reported they had spoken to the PSW, and the PSW confirmed care was provided to the resident.

The DOC and ADOC reported the PSW was not to provide the resident care. The DOC and ADOC agreed the PSW was aware they were to switch their assignment with a co-worker if they got assigned to the resident's care by the charge nurse.

There was risk identified when the licensee failed to ensure that the resident's right to participate in decision-making was respected.

Sources: CIR, clinical records, interviews with the resident, ADOC and the DOC. [741753]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that the care set out in the resident's care plan was reassessed, when the resident's transfers status changed, and the application of the assistive devices to the resident's wheelchair were no longer required.

Rationale and Summary:

A CIR was submitted to the Director indicating the resident had an unwitnessed fall. The resident was transferred to hospital, and returned home the same day, with an injury.

Prior to the fall the resident's care plan indicated the resident ambulated with a walker. The resident required one staff supervision with transfers. Post falls the resident's care plan indicted the transfer status had changed. The resident required a device to transfer, and they required assistive aids to be attached to the wheelchair.

The PSW reported the resident's transfer was a two person assist and the resident no longer required the assistive devices on the wheelchair.

The RPN agreed the care plan indicated the resident's transfer was staff using an assistive device, however the resident transfers status had changed, and they were a two person assist. The RPN observed the resident with the inspector and agreed the assistive devices to the resident's wheelchair were not applied as indicated in the care plan. The RPN reported the resident no longer required the assistive device on their wheelchair, as the resident's ambulation had improved. The RPN indicated they would send a Physiotherapist (PT) referral for a reassessment and applied the assistive devices to the resident's wheelchair.

The PT confirmed the resident's current transfer status was one to two persons assist. The PT reported the assistive devices were implemented as a comfort measure after the fall. The PT reported the resident's mobility had improved, and they were reassessing the resident that day, regarding their transfer status and if the assistive devices were still required to be applied to the wheelchair.

The resident may have been at risk for receiving improper care when the plan of care was not revised.

Sources: CIR, clinical records, interviews with staff and the Physiotherapist.

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

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

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure without in any way restricting the generality of the duty provided for in section 24, that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director, reporting a PSW overheard another PSW #115, shouting at a resident for reporting a concern to management.

The DOC reported they came into work and noticed a letter under their door, signed by a PSW. The letter indicated they overheard a conversation between PSW #115 and the resident, the PSW was unhappy with the resident for speaking to management. The PSW reported the resident was also upset about the

conversation that had occurred. The PSW's statement further indicated they were keeping what they heard to themselves but could not take their conscience that they did not do anything for the resident. The DOC started the investigation and submitted a CIR for abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

The PSW reported they overheard a conversation between PSW #115 and the resident, the PSW was unhappy with the resident for speaking to management. The PSW reported the resident was upset after the conversation with PSW #115 and talked to them about what had occurred, for days after the incident. The PSW reported they kept what they had overheard between PSW #115 and the resident to themselves. The PSW reported they felt guilty about not reporting the incident and weeks later told the DOC what they had overheard between PSW #115 and the resident. The PSW reported the DOC asked them to write a statement.

The DOC reported they were not aware the incident occurred weeks prior to the PSW reporting the incident to them. The DOC reported they understood the incident was reported to them the following day. The DOC acknowledged the PSW should have reported the incident immediately to the Charge Nurse that evening when they overheard the conversation.

The home's policy indicated there is a zero tolerance for abuse of any type. There is zero tolerance with respect to failure to report abuse of any kind. This includes abuse from any person. Abuse reporting is immediate and mandatory. All employees are required to internally report to ensure safety for all, report immediately to their respective supervisor/person in charge of the building when: abuse is witnessed and/or abuse is suspected and/or at any time information or knowledge of an allegation of an abuse is received or learned from any person.

Failing to ensure the homes policy to promote zero tolerance for abuse and neglect is complied with by the PSW increased the risk for the resident to be abused by PSW #115.

Sources: CIR, the home's policy, interviews by staff and the DOC. [741753]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure the Director was immediately informed when a reported an allegation of abuse.

Rationale and Summary:
A complaint was received to the Director by a resident indicating a co-resident had responsive behaviours, resulting in a physical and verbal altercation.

The resident 's progress notes indicated a co-resident wandered into their room, an argument ensued, resulting in a resident-to-resident altercation, and one resident sustaining an injury.

The ADOC confirmed the verbal and physical altercation between the two residents should have been reported immediately to the Director.

Failing to immediately report to the Director did not have impact or risk to the resident's health, safety, or quality of life.

Sources: The home's investigation notes, clinical records, interview with the ADOC. [741753]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the resident-staff communication and response can be easily seen.

Rationale and Summary:
A complaint was submitted to the Director related to delay in call bell response time and staff turning off the call bell without attending to the resident's needs.

An interview was conducted with a PSW, to discuss the communication system and how staff respond when a resident rings their call bell. The PSW demonstrated how the call bell system worked in a resident room, a semiprivate room which shared a bathroom, with an adjacent resident room. The PSW pressed the call bell at the resident's bedside and the resident's shared bathroom, an audible sound was heard outside the room. At the same time the communication panel across from the nursing station, displayed the resident's room number. When the PSW deactivated the call bell in the bathroom, the light on the communication panel, was also no longer visible. Further observation of the light display panel outside the resident's

room indicated it could not be easily seen as the fire door was open and blocking the light display above the resident's door. The PSW agreed they could not see if the light was on in the display panel outside the resident's room, as the open fire doors were blocking the light panel.

The Administrator and Environmental Service Manager (ESM) reported the home's visual communication system on Mill Street, included the display panel lighting up above the resident's door and the resident room number being displayed on the communication panel across from the nursing station. The Administrator and ESM confirmed when staff activate the call bell in shared resident bathrooms and a resident is activating their call bell at the bedside, the communication panel at the nursing station no longer displays the resident room number when the PSW cancels the bathroom bell. The Administrator and ESM further confirmed the light display outside the resident's room remained on however could not be easily seen by staff, as the open fire doors are blocking the light panel.

The residents were at risk for delayed care when the communication system was not easily seen.

Sources: Observations, interviews with the Administrator and Environmental Service Manager. [741753]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 20 (g)

Communication and response system

s. 20 (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The licensee has failed to ensure that the resident-staff communication and response system was properly calibrated so that the level of sound is audible to staff.

Rationale and Summary:
A complaint was submitted to the Director related to delay in call bell response time and staff turning off the call bell without attending to the resident's needs.

An interview was conducted with the PSW, to discuss the communication system and how staff respond when a resident rings their call bell. The PSW demonstrated how the call bell system worked in a resident's room, a semiprivate room with a shared a bathroom, with an adjacent room. The PSW activated the call bell at the resident's bedside, one audible beep was heard outside the room. At the same time the communication panel across from the nursing station, displayed the resident's room number, indicating to staff the resident at the bedside in the room required assistance. During the same demonstration the PSW activated the bathroom bell and the communication panel continued to display the room number and two audible beeps were heard. The PSW agreed when they cancelled the call bell in the shared bathroom the light on the communication panel was no longer visible and there was no longer an audible sound indicating the resident at the bedside in the room was still calling for staff assistance.

That same day the communication system was observed with staff working on the same unit for two other resident rooms. The two resident room's share the bathroom. Observation of these rooms indicated when the staff activated the call bell at the resident's bedside in one room, simultaneously with bathroom bell, the light above the resident's door lit up, the display panel displayed the residents room number, and the communication system was audible in the hallway. When the staff deactivated the bathroom bell, the communication panel across from the nursing station no longer displayed the resident room number, and the communication

system was no longer audible to alert staff the resident at the bedside in the room still required assistance.

The Administrator and Environmental Service Manager (ESM) agreed when a resident activates their call bell at the bedside in a semiprivate room, simultaneously with a resident activating the call bell in the shared bathroom with an adjacent room, the communication system is no longer audible to staff alerting them that the resident at the beside still requires assistance when staff deactivate the bathroom bell.

The residents were at risk for delayed care when the communication system was no longer audible.

Sources: Observations, interviews with staff, the Administrator and Environmental Service Manager. [741753]

WRITTEN NOTIFICATION: PERSONAL ITEMS AND PERSONAL AIDS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee has failed to ensure residents had their personal items labelled.

Rationale and Summary:

A complaint was received by a resident indicating the PSW did not provide their oral care as indicated.

Unlabeled toiletry items were observed on the back of the toilet in a resident's bathroom.

PSW #105 acknowledged the unlabeled toiletry supplies on the back of the toilet were the residents. The PSW further acknowledged the toiletry supplies for the resident should be labeled. PSW #103 reported each resident has their own basket where their toiletry supplies were kept, and the resident's toiletry supplies were not required to be labeled.

That same day PSW #104 was observed at the nursing station they reported they were looking for a marker to label the supplies in their hands. The PSW reported the assigned PSW caring for the resident was responsible for ensuring the resident's personal items, including toiletries were labeled.

On a different home area it was observed that the shower room door was open. Inside the shower room was an open cupboard mounted to the wall, inside were unlabeled toiletries. ADOC #109 was aware of the inspector's observation.

ADOC #109 and the DOC confirmed all toiletries and personal items are to be individualized and labeled for each resident.

Failing to ensure residents' personal items are labeled and individualized increases the risk for the spread of infection in the home and for the residents' personal items to be misplaced.

Sources: Observation, interviews with staff, ADOC #109 and the DOC. [741753]

WRITTEN NOTIFICATION: FALLS PREVENTION AND

MANAGEMENT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary:

A CIR was submitted to the Director indicating a resident had an unwitnessed fall and was transferred to hospital later that day. The resident returned home the same day, diagnosed with an injury.

The RPN confirmed they were the unit nurse working the day the resident. The RPN reported they started the post fall assessment but did not complete the assessment as they did not know how. The RPN further reported they were not aware they were responsible for completing the post falls assessment the same day the resident fell.

The Post Falls Assessment in Point Click Care (PCC) indicated the post falls assessment was completed by a RN, two days after the resident fell.

The ADOC's agreed the post falls assessment was not completed the day the resident fell and reported the resident's post falls assessment should have been completed the same day the resident fell.

The home's policy indicated a Post Fall Assessment and Analysis should have been completed in PCC by the interdisciplinary team following a fall incident. In the event

of a fall the registered staff will Registered staff will complete section one of the Post Fall Assessment and Analysis in PCC. The registered staff will announce and conduct the post fall huddle at the location where the resident fell and complete section two of the Post Fall Assessment and Analysis. The registered staff and team members who discovered or witnessed the occurrence must be present.

The resident was at risk for further falls and injuries untreated when the staff did not complete the required post fall assessments.

Sources: CIR, the home's policy, clinical records, interview with staff and the ADOC's. [741753]

WRITTEN NOTIFICATION: REPONSIVE BEHAVIOURS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee of a long-term care home shall ensure that written strategies for a resident, included techniques and interventions, to prevent, minimize resident or respond to their responsive behaviours.

Rationale and Summary:
A CIR was submitted to the Director, indicating two residents had responsive behaviours, a resident-to-resident physical alteration occurred, resulting in one of the resident's falling and sustaining an injury.

Prior to the altercation that occurred between the two residents, Resident #003's clinical records indicated they had responsive behaviors towards other residents and staff and the resident was not easily redirected.

Resident #003's clinical records indicated, resident #003 and resident #004 engaged in an alteration. During the altercation resident #004 fell and sustained an injury. The charge nurse implemented interventions for resident #003.

The PSW #117 reported resident #003 was easily directed, and they did not really get upset with other residents. The PSW reported the resident went to the nursing station and sat and conversed with other residents.

The RPN reported resident #003 is up walking in the hallway and may have responsive behaviours towards other residents. The RPN reported there were interventions in place to ensure co-residents remained safe when the resident was walking the hallway.

The BSO lead and DOC reported resident #003 could have responsive behaviours when they were walking the in the hallway. The DOC and BSO lead indicated there were interventions to protect other residents and keep them safe from resident #003's responsive behavior when they walked in the hallway.

The BSO lead agreed resident #003's interventions had not been updated to ensure staff were aware of these interventions to manage the resident's responsive behaviours when the resident ambulated in the hallway.

The resident's safety may have been at risk when resident #003's interventions were not updated, and staff were not aware of the interventions.

Sources: CIR, clinical records, interviews with staff, the BSO Lead and DOC. [741753]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure actions are taken to respond to the needs of a resident, including assessments, reassessments and interventions and the that the resident's response to interventions are documented.

Rationale and Summary:
1) A CIR was submitted to the Director, indicating a resident-to-resident altercation, causing one resident to fall and sustain an injury.

Resident #003 and resident #004 engaged in an alteration causing resident #004 to fall and sustain an injury. The charge nurse implemented interventions for resident #003.

A monitoring tool was implemented for resident #003 and was completed by the staff for five days.

The Registered Nurse (RN) reported the PSW normally completes the monitoring tool. Once the monitoring tool is completed it is put in the BSO leads mailbox and they analyze the completed form.

The BSO lead confirmed they analyze the completed monitoring tool, and based on the assessment, speaking with staff, and observing the resident, they may implement new interventions. The BSO lead reported they had been away and

confirmed the resident's monitoring tool had not been analyzed for these five days. For another month, the resident was monitored by staff using the same monitoring tool. The BSO lead confirmed the completed tool was not analyzed for the following month as they were not working at the home during this time.

The resident, co-resident's and staff were at an increased risk for harm when the completed monitoring tool was not analyzed by the BSO lead or another staff member.

Sources: CIR, clinical records, interviews with staff and the BSO lead. [741753]

The licensee has failed to ensure actions are taken to respond to the needs of a resident, including assessments, reassessments and interventions and the that the resident's response to interventions are documented.

Rationale and Summary:
2) A complaint was received to the Director by a resident indicating another resident entered their room, resulting in an altercation.

The resident care plan indicated the resident had responsive behaviours towards other residents and to complete a monitoring tool when needed.

ADOC #108 confirmed the monitoring tool was not started when the altercation occurred between the two residents. The ADOC reported the monitoring tool should have been completed when the resident-to-resident altercation occurred, and acknowledged the residents care plan should have provided staff clearer direction when to complete the monitoring tool.

When staff did not complete the monitoring tool, there was an increased risk that appropriate assessments, reassessments and interventions may be missed to manage the resident responsive behaviours.

Sources: Clinical records, interview with the ADOC. [741753]

WRITTEN NOTIFICATION: NOTIFICATION RE INCIDENTS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being;

The licensee failed to shall ensure the residents substitute decision maker was notified immediately when a resident to resident alteration occurred which resulted in one of the residents sustaining a injury.

Rationale and Summary:
A complaint was received to the Director by resident #001 indicating another resident had entered their room, resulting in an altercation.

The RPN documented in resident #006's clinical records and noted the resident had an injury. The RPN documented treatment was done to the area, and the residents POA was informed, a note was left in the Physician's binder and noted in the Treatment Administration Record (TAR), hygiene care, on shower days.

ADOC #108 acknowledged the RPN did not document the altercation between the two residents in the resident #006's clinical records. The ADOC agreed the documentation by the staff indicated they called the POA to inform them the

resident had an injury but did not indicate if the POA was informed of the altercation between the two residents.

ADOC #108 acknowledged they completed the investigation. The ADOC was not able to confirm if the POA was updated when the resident-to-resident altercation, and this was the reason why the resident had sustained an injury.

There was minimal risk of harm to the resident when notification requirements were not met.

Sources: Clinical records and interviews with the ADOC. [741753]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint.

The licensee has failed to ensure that a documented record was kept in the home that included the nature of each written complaint involving the resident.

Rationale and Summary:
A complaint was received by a resident indicating the PSW did not provide their oral care as indicated.

The home's policy indicates a complaint means a statement/ expression either verbally or in writing that indicates something is unsatisfactory or unacceptable. The policy indicates verbal complaints resolved within 24 hours will be logged in the complaint workbook and on the tab titled Verbal COMP, resolved twenty-four-hour, verbal complaint that cannot be resolved within 24 hours after receipt will be fully

investigated.

ADOC #109 reported they were aware of the incident when the PSW did not provide the resident oral care as indicated. The ADOC reported they spoke to the resident about what happened. The ADOC further reported they spoke to the PSW, to investigate how this had occurred. The PSW reported they did not have their glasses on, and they reported what happened was a mistake. The ADOC reported they told the PSW they needed to apologize to the resident and as far as they knew this had occurred.

A review of the home's complaint binder indicated that there was no logged record of the complaint for September or October 2023.

ADOC #109 acknowledged the incident should have been documented indicating what had occurred, and how this incident was addressed by staff. The ADOC reported they spoke to the PSW, and resident, about the incident. The ADOC agreed the conversations they had were not documented in the resident's clinical records, nor was the complaint logged in the complaint's binder.

Failing to ensure that a documented record is kept in the home that includes, the nature of each verbal complaint, the inspector was not able to determine if the verbal complaint was resolved in twenty-four hours and confirm how the complaint was followed up by the management team.

Sources: home's policy interviews with the resident and ADOC #109. [741753]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee has failed to ensure a documented record is kept of every date on which a response was provided to the resident and a description of the response.

Rationale and Summary:
A Critical Incident Report (CIR) and complaint was submitted to the Director related to an allegation of staff to resident abuse.

The resident reported a PSW was pushing another resident in their wheelchair, when they hit their wheelchair causing them pain. The resident reported management did not follow up with their complaint.

The DOC spoke to the resident, as part of their investigation related to the above CIR submitted the same day. The DOC's investigation notes indicated the resident reported the PSW had intentionally bumped their wheelchair, while they were transporting another resident. The DOC interviewed the resident as to why they felt this way. The resident felt the PSW was upset with them. A few days later a documented conversation occurred with the Administrator, the DOC and the PSW. The PSW agreed the incident had occurred and reported they had apologized and notified the nurse about the incident and the resident's reported pain.

The DOC reported they did not investigate the resident's complaints, as they believed the incident happened prior to the date they interviewed the resident. The DOC reported they believed the incident was investigated by ADOC #109. ADOC #109 reported they were not aware of the complaint from the resident The ADOC confirmed they had no investigation notes regarding this incident. The complaints

log was reviewed for May, June, July, August and September 2023, there was no logged complaints regarding this incident.

The home's policy indicates the home must keep a documented record about all complaints received which includes, every date on which any response was provided to the complainant and a description of the response.

When the licensee failed to retain documented records of the dates, they provided the resident a response to their complaint, the inspector was not able to determine if the resident was given a response regarding the outcome of the licensee's investigation.

Sources: CIR, home's policy, investigation notes, interviews with ADCO #109 and the DOC. [741753]