Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 25, 2021 | 2021_725522_0005 | 025784-20, 005727-21, 006689-21, 007023-21, 007029-21 | Critical Incident System |

### Licensee/Titulaire de permis

S & R Nursing Homes Ltd.
265 North Front Street Suite 200 Sarnia ON N7T 7X1

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

Afton Park Place Long Term Care Community
1200 Afton Drive Sarnia ON N7S 6L6

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

JULIE LAMPMAN (522), DEBRA CHURCHER (670)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): May 12, 13, 17, 18, 19, 20, 21, 25, 26, and 27, 2021.**

**The following Critical Incident System (CIS) intakes were inspected:**

**CIS report #2872-000009-21/Log #006689-21 related to staff to resident abuse;**
**CIS report #2872-000011-21/Log #007023-21 related to staff to resident abuse;**
**CIS report #2872-000012-21/Log #007029-21 related to staff to resident abuse;**
**CIS report #2872-000006-21/Log #005727-21 related to falls prevention;**
**CIS report #2872-000024-20/Log #025784-20 related to falls prevention.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Assistant Manager of Resident Care, Manager of Environmental Services, Office/Staffing Coordinator, Registered Nurses, Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Resident Care Aide, a Life Enrichment Worker, a Dietary Aide, Housekeepers, an agency RPN, a student RPN, an agency PSW, an agency Medical Laboratory Technologist, a Security Guard, a Screener, a Bluewater Health Senior Infection Control Practitioner and residents.**

**The inspector(s) also observed staff to resident interactions, infection prevention and control practices in the home, the provision of resident care, reviewed resident clinical records, staff training, the home's program evaluations and policies and procedures related to this inspection.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**
**Prevention of Abuse, Neglect and Retaliation**

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

**12 WN(s)**
**2 VPC(s)**
**10 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A) Directive #3 for Long-Term Care Homes (LTCH) under the LTCH Act 2007 dated May 4, 2021, noted “All individuals must be actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the LTCH. For clarity, staff and visitors must be actively screened once per day at the beginning of their shift or visit.”

i) On a specific date, when Inspector #522 was in the screening area and was being screened, Staff Member #133 entered the screening area took their temperature and proceeded to exit through the gate from the screening area into the home when Screener #109 stopped them and asked if they had any new symptoms. Staff Member #133 stated they had no change, left and did not finish the screening process.

Screener #109 stated staff were to wait to be screened before entering the home. Screener #109 stated that Staff Member #133 should not have entered the screening area as only two people were allowed in the screening area at a time.

Review of the home’s screening tool sheets for staff over a four day period, noted a temperature was recorded but not all staff members had completed the required screening questions.

Review of Staff Member #133’s screening from the day they did not complete screening, noted two of the screening questions had been answered as ‘no’ when the questions had not been asked.

ii) Review of the 2 East -Somerset screening binder during the home area’s COVID-19 outbreak noted, “Staff and Essential Caregivers: Please screen yourself in and out for every shift/visit (record the time, your name, temperature and answer all your questions)”.

Review of the 2 East Screening Tools over a two day period, noted not all staff members had answered all the required screening questions.

There were four pages with no date entered. Of those pages, not all staff members answered all the required screening questions and/or took their temperature upon entering the home.

In an interview, the Administrator stated they did not want 2 East staff going through the front with the other staff and had the 2 East staff use a separate entrance and passively screen.

Sources:
Observations of the staff screening process, review of the home's screening tools and interviews with Screener #109, the Assistant Manager of Resident Care (AMRC), MRC and Administrator.

B) During an Infection Prevention and Control tour of the home, Inspector #522 observed an essential caregiver leaving the screening area to enter the vestibule. The essential caregiver had taken their coat from the coat rack in the screening area and put it on over their gown to go into the vestibule to remove their Personal Protective Equipment (PPE).

C) Directive #3 for Long-Term Care Homes (LTCH) under the LTCH Act 2007 dated May 4, 2021, noted, "All staff and essential visitors are required to wear appropriate eye protection (e.g., goggles or face shield) when they are within 2 metres of a resident(s) as part of provision of direct care and/or when they interact with a resident(s) in an indoor area." Under information and training the directive recommends that "LTCHs must provide all health care workers, other staff, and any essential visitors who are required to wear PPE with information on the safe utilization of all PPE, including training on proper donning and doffing."

On a specific date, while Inspector #522 was doffing their PPE in the vestibule the screener let an essential visitor into the vestibule area. While inspector was leaving the parking lot they observed that the essential visitor had not doffed their face mask and had the reusable face shield hanging around their elbow.

In an interview, the MRC stated essential caregivers had been given face shields to take home since Directive #3 required the use of face shields in the home. The MRC stated

the essential caregivers were never educated on how to disinfect and store the face shields.

Inspector #522 received an email forwarded from the Bluewater Health Senior Infection Control Practitioner noting that Public Health Ontario (PHO) had stated from a risk mitigation, the home could train essential caregivers on properly disinfecting the reusable face shield and the face shield should be stored onsite at the home.

Sources:
IPAC tour of the home, observations of visitors; review of Steeves & Rozema's Visitation and Testing policy RCM 05-16 revised May 11, 2021, email correspondence to essential caregivers from the home dated March 24, 2021, April 14, 2021 and May 19, 2021, email correspondence from PHO; interviews with Screener #109, the Bluewater Health Senior Infection Control Practitioner,  AMRC, MRC and Administrator. [s. 5.]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2:  The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.  2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Review of resident #001's clinical record showed resident #001 had experienced a fall.

Review of resident #001's Post Fall Risk Management, showed that resident #001 had experienced a fall and a specific falls intervention was not in place at the time of the fall.

Review of resident #001's plan of care prior to the fall and current plan of care stated that the resident was to have specific falls interventions in place.

On a specific date, Inspector #670 observed resident #001 seated in their room without two specific falls intervention in place.

B) Review of resident #005's clinical record showed resident #005 had experienced a fall.

Review of resident #005's Post Fall Risk Management showed that resident #005 had experienced a fall and a specific falls intervention was not in place at the time of the fall.

Review of resident #005's plan of care in place at the time of the fall stated that the resident was to have specific falls interventions in place.

Sources:
Resident #001 and #005 clinical records, observations of resident #001, interview with MRC. [s. 6. (7)]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to protect resident #002, #003 and #004 from abuse from Personal Support Workers (PSWs) #123 and PSW #124.

Ontario Regulation 79/10 defines emotional abuse as “any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Ontario Regulation 79/10 defines verbal abuse as “any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.”

A) During a workplace harassment investigation, Staff Member (SM) #125 told management that Personal Support Workers (PSWs) #123 and #124 had made a comment while resident #004 was coming down the hall that SM #125 should dance and made a negative comment about resident #004’s diagnosis.

A review of PSW #124’s employee record noted on several occasions PSW #124 had been verbally abusive and inappropriate with residents.

In an interview, SM #125 stated on a specific date, PSW #123 and PSW #124 were dancing in the hallway of the home area and PSW #123 had made an inappropriate action. SM #125 stated PSW #123 saw resident #004 was coming down the hall with another staff member and the PSWs told SM #125 to do the same inappropriate action to resident #004. SM #125 stated they were unsure if resident #004 heard the PSWs comment.

B) During the same investigation, Personal Support Worker (PSW) #110 told management that PSW #124 had verbally abused resident #002 when they were getting

the resident out of bed with PSW #110. PSW #110 stated resident #002 probably heard the comment as PSW #124 was right beside resident #002 when they made the comment, but the resident did not respond or react.

In an interview, PSW #110 stated when working with PSW #124 on a specific date, PSW #124 swore at resident #002. PSW #110 stated they did not say anything to PSW #124 or report the incident to management until they were interviewed as part of a workplace harassment complaint.

C) Personal Support Worker (PSW) #110 also told management that on the following day, while sitting at the nurses station with Registered Practical Nurse (RPN) #127 and PSW #124, resident #003 came to the nurses' station window and PSW #124 was verbally abusive to the resident.

In an interview, PSW #110 stated when working with PSW #124, resident #003 kept coming to the nurses' station and PSW #124 got annoyed. PSW #110 stated RPN #127 told PSW #124 that they needed to be nice to resident #003.

In an interview, PSW #126 stated when they had worked with PSW #124 and were leaving resident #003's room, PSW #124 stated to PSW #126 that resident #003 should just die. PSW #126 stated they did not think resident #003 would have heard the comment.

In an interview, RPN #127 stated they did not hear exactly what PSW #124 stated to resident #003 at the nurses station. RPN #127 stated they had spoken to PSW #124 in the past regarding how they had spoken with resident #003. RPN #127 stated they did not feel that was appropriate.

Sources:
Critical Incident System (CIS) reports #2872-00009-21, #2872-000011-21 and #2872-000012-21, the home's investigative notes, residents #002, #003 and #004's clinical records and PSW #124's employee record; and interviews with PSW #110, PSW #126, RPN #127, SM #125, Life Enrichment Worker #135, the MRC and Administrator. [s. 19. (1)]

***Additional Required Actions:***

***CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of Steeves & Rozema's "Resident Abuse and Neglect" policy noted in part: "Any employee or volunteer who witness an incident of resident abuse, or has knowledge of an incident that constitutes resident abuse or neglect, will intervene and implement strategies to ensure the safety of every resident and staff member."

"Any employee or volunteer who witness an incident of resident abuse, or has knowledge of an incident that constitutes resident abuse or neglect, will immediately inform the Administrator, Manager Resident Care (MRC), or in their absence, the Charge Nurse/delegate in the home, of any incident of suspected or witnessed abuse. The Charge Nurse/Delegate will then immediately notify the Administrator or MRC."

A) In an interview Staff Member (SM) #125 stated PSW #124 and PSW #123 were dancing and PSW #123 made an inappropriate action. SM #125 stated PSW #123 saw resident #004 was coming down the hall with a staff member the PSWs told SM #125 to do the same inappropriate action to resident #004.

SM #125 stated they did not do anything other than tell the PSWs that they would not do the inappropriate action, nor did they report the incident when it occurred. They had only reported the incident to the Manager of Resident Care when they were being interviewed

as part of a separate investigation, which was 15 days after the incident.

B) In an interview, PSW #110 stated when PSW #124 swore at resident #002 they did not say anything to PSW #124 or resident #002. PSW #110 also told management that the following shift, while sitting at the nurses' station with Registered Practical Nurse (RPN) #127 and PSW #124, resident #003 approached the window at the nurses' station to get their attention and PSW #124 was verbally abusive to resident #003.

PSW #110 stated they reported the incidents to management over a week later. PSW #110 stated they should have reported the incidents when they happened but stated they had reported a previous staff member and felt nothing had been done.

C) During an investigation into a workplace harassment complaint, PSW #126 told management that they had seen PSW #124 be verbally abusive to residents, including resident #003.

Sources:
Critical Incident System (CIS) reports #2872-000009-21, #2872-0000011-21, and #2872-0000012-21, the home's investigative notes, residents #002, #003, and #004's clinical records; interviews with PSW #110, PSW #126, RPN #127, SM #125, the MRC and Administrator. [s. 20. (1)]

***Additional Required Actions:***

***CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures**

**Specifically failed to comply with the following:**

**s. 75. (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2); 2015, c. 30, s. 24 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that police record checks were conducted prior to hiring staff members.

LTCHA 2007 c.8 defines staff as “persons who work at the home pursuant to a contract or agreement with the licensee, or pursuant to a contract or agreement between the licensee and an employment agency or other third party.”

Directive #3 for Long-Term Care Homes (LTCH) under the LTCH Act, 2007 dated March 20, 2020, noted the following amendments to Ontario Regulation 79/10:

“Before a staff member is hired or a volunteer is accepted by a licensee, the licensee must require that the staff member or volunteer provide the licensee with a signed declaration disclosing specified charges and convictions for offences since the date the person’s last police record check was conducted, or if no such police record check has been conducted, of all occurrences.”

Review of Personal Support Worker (PSW) #123’s employee record noted that PSW #123’s police check was dated two years prior to their hire date.

On a specific, Security Guard (SG) #104 was observed providing 1:1 support to a resident. Review of SG #104’s employee file noted there was no police check or signed declaration disclosing specified charges and convictions for offences on file.

Review of employee files of new agency hires for PSW #128, #129, and #130 noted no police check on file for PSW #128 and #130 and PSW #129’s police check was outdated. There was no signed declaration disclosing specified charges and convictions for offences on file.

Sources:
Review of Critical Incident System report #2872-000009-21, the home’s “Police Record Check” policy #7.1.38 with a revision date of April 14, 2021, employee files for PSWs #123, #128, #129 and #130 and SG #104 and interview with the Office/Staffing Coordinator and the Administrator. [s. 75. (2)]

***Additional Required Actions:***

***CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:**
**1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).**
**2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).**
**3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).**
**4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).**
**5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).**
**6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).**
**7. Fire prevention and safety. 2007, c. 8, s. 76. (2).**
**8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).**
**9. Infection prevention and control. 2007, c. 8, s. 76. (2).**
**10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).**
**11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).**

**s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff had received training related to the following prior to performing their responsibilities:
• The Residents' Bill of Rights;
• The LTC home's policy to promote zero tolerance of abuse and neglect of residents;

• The duty to make mandatory reports under section 24.

Directive #3 for Long-Term Care Homes (LTCH) under the LTCH Act, 2007 dated March 20, 2020, noted the following amendments to Ontario Regulation 79/10:

“Training must be provided within one week of the staff member beginning to perform their responsibilities on the following:
• The Resident’s Bill of Rights;
• The LTC home’s policy to promote zero tolerance of abuse and neglect of residents;
• The duty under s. 24 of the LTCHA to make mandatory reports.”

Review of employee files for recent new agency hires noted PSWs #128, #129 and #130 did not have documentation of the above training.

Sources:
Review of the home’s “Orientation policy” #09-02 with a revision date of December 28, 2017, interviews with the Administrator. [s. 76. (2)]

2. The licensee has failed to ensure that all staff received training in infection prevention and control related to COVID-19.

Ontario Regulation 79/10 s. 219 (1) requires annual training in relation to infection prevention and control.

Throughout the inspection some staff members were observed not social distancing, not wearing their mask appropriately or not at all, and not sanitizing their hands after doffing their mask.

A staff member was also observed not completing mandatory active screening for COVID-19 upon entry to the home.

Review of the home’s screening records noted not all staff members were answering all required screening questions.

In an interview, the Assistant Manager of Resident Care (AMRC) stated staff were to read the required COVID-19 education and sign that they had read the information and then this was entered into Surge Learning.

Review of the home's Infection Prevention and Control training for all departments related to COVID-19 in Surge Learning noted the following:

1) Coronavirus dated February 14, 2020 - 24 out of 165 (14.5%) completed.

2) COVID-19 FAQ dated March 6, 2020 – 37 out of 165 (22.4%) completed.

3) COVID-19: Infection Control Directive and Policy 7.1.72 COVID-19 Entering and Leaving the Workplace dated March 31, 2020 – 34 out of 168 (20.2%) completed.

4) Pandemic Safety Measures – reminder memo dated July 9, 2020 - 58 out of 165 (35.2%) completed.

5) COVID-19 Protocols Refresher dated December 3, 2020 -38 out of 165 - (23.0%) completed.

In an interview, the Manager of Resident Care (MRC) stated the previous Resident Care Coordinator was responsible for the education and tracking.

The MRC stated they also sent information out by email and posted in the message board in Point Click Care but were unable to provide inspector any further education or training from 2020.

Sources:
Review of the home's training records, interviews with the AMRC, MRC and Administrator. [s. 76. (4)]

3. The licensee has failed to ensure that all staff had received retraining annually related to the following:
• The Residents' Bill of Rights;
• The duty to make mandatory reports under section 24;
• The whistle-blowing protections.

Review of the home's 2020 Surge Learning noted the following:
70 out of 138 (50.7%) staff completed Critical Incidents/Mandatory Reporting/Whistleblowing protection training.
94 out of 138 (68.1%) staff completed Resident Bill of Rights training.

Sources:
Review of the home's "Team Member Education" policy #09-01 with a revision date of December 28, 2017, 2020 Surge Learning training, interviews with the MRC and Administrator. [s. 76. (4)]

***Additional Required Actions:***

***CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 staff receive training prior to perform their responsibilities on the following:***
***• The Residents' Bill of Rights;***
***• The LTC home's policy to promote zero tolerance of abuse and neglect of residents;***
***• The duty under s. 24 of the LTCHA to make mandatory reports, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's Fall Prevention and Management Program policy was complied with.

A) The home's policy titled Fall Prevention and Management Program RCM 10-02-01, revision date May 8, 2019 stated "A head injury protocol will be followed when a resident receives an injury to the head, a suspected injury to the head or an unwitnessed fall".

During an interview with the MRC, the Head Injury Routine (HIR) form was reviewed and the MRC confirmed that the policy of the home was to complete HIR assessments every half hour for four assessments followed by every hour for four assessments followed by every two hours for four assessments then on the day and evening shift for two days.

Risk management notes stated that resident #001 had two unwitnessed falls.

Review of resident #001's HIR documentation showed that resident #001 did not have a HIR assessment completed in full after each fall.

B) Risk management note stated that resident #006 had an unwitnessed fall.

Review of resident #006's HIR documentation showed that resident #006 did not have a HIR assessment completed in full after the fall.

C) Risk management note stated that resident #007 had a fall and stated that they hit their head.

Review of resident #007's HIR documentation showed that resident #007 did not have a HIR assessment completed in full after the fall.

Sources:
Review of the homes falls prevention and HIR policy, review of residents #001, #006 and #007 HIR documentation, and interview with the MRC. [s. 8. (1)]

***Additional Required Actions:***

***CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

**Specifically failed to comply with the following:**

**s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents #002, #003 and #004's Substitute Decision Makers (SDMs) were notified of the results of an abuse investigation immediately upon the completion of the investigation.

A) Personal Support Worker (PSW) #110 had reported to management that they had witnessed PSW #124 verbally abuse resident #002.

B) Personal Support Worker (PSW) #110 had reported to management that they had witnessed PSW #124 verbally abuse resident #003.

C) On a specific date, the home initiated an investigation into an allegation of emotional abuse towards resident #004 from Personal Support Workers #123 and #124.

Review of resident #002, #003 and 004's progress notes indicated their SDMs had not been updated on the results of the home's investigation into the abuse.

In an interview, the Manager of Resident Care (MRC) stated they had not informed resident #002, #003 and #004's SDMs of the results of the investigation.

Sources:

Review of Critical Incident Report (CIS) reports #2872-00009-21, #2872-000011-21, and #2872-000012-21, the home's investigative notes, residents #002, #003 and #004's clinical records and interview with the MRC. [s. 97. (2)]

***Additional Required Actions:***

***CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following:**

**s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:**
**1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).**
**2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all staff who provided direct care to residents, received training relating to abuse recognition and prevention annually.

Review of the home's "Team Member Education" policy noted annual abuse education was in person for all staff.

In an interview, the Manager of Resident Care (MRC) stated the home had not completed in person abuse training in 2020 due to the pandemic and there was no additional staff training completed in place of the in person abuse training.

Sources:
Review of the home's "Team Member Education" policy #09-01 with a revision date of December 28, 2017, interviews with the MRC and Administrator. [s. 221. (2)]

***Additional Required Actions:***

***CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

1) During observations of a home area with the Assistant Manager of Resident Care (AMRC), Inspector #522 observed Personal Support Worker (PSW) #102 pour a drink and give it to a resident and touch the resident on the back. The PSW returned to the snack cart, wheeled it down the hall and proceeded to pour another resident a drink. PSW #102 did not sanitize their hands in between residents and inspector observed there was no hand sanitizer on the snack cart.

The Assistant Manager of Resident Care (AMRC) stated to PSW #102 that there was to be hand sanitizer on the snack cart.

Review of Steeves and Rozema's "Hand Hygiene" policy noted hand hygiene should be performed before initial contact with each resident or items in their environment and after contact with a resident or their environment.

In an interview, the AMRC stated staff should sanitize their hands before and after each contact with a resident during snack service and staff should have hand sanitizer on the snack cart for easy access to sanitizer.

2) During an Infection Prevention and Control tour of the home, Inspector #522 observed staff bringing residents down for lunch and sitting them at their table in the dining room.

Inspector #522 observed Security Guard (SG) #104 assist a resident from a common area to the dining room on a home area. SG #104 assisted the resident to sit down at a table and gave them a clothing protector but did not assist the resident to wash their hands.

In an interview, SG #104 stated they were working 1:1 with the resident and they did not wash the resident's hands before or after meals.

In an interview, PSW #102 stated they were uncertain if they should sanitize residents' hands before meals, but they did wash residents' hands after meals.

Review of Steeves & Rozema "Dining Program" policy noted "All residents will be provided with the opportunity to wash/wipe their hands and face before and after his/her meals."

In an interview, AMRC stated all residents should have their hands washed before and after meals.

3) i) On a home area, Inspector #522 observed two staff seated in the Resident Care Centre area through the window. Staff were seated chatting and one staff member had their mask pulled down below their chin.

ii) Inspector observed a designated break room for staff due to the COVID-19 outbreak on the home area. Inspector observed two staff members seated at separate tables socializing without masks on.

iii) On a home area, inspector observed Dietary Aide #131 in the dining area with their mask only covering their mouth. Inspector asked DA #131 if they were aware they were to wear their mask over their nose. DA #131 did not say anything and pulled their mask up over their nose.

4) Inspector #522 observed a home area which was in a COVID-19 outbreak with the AMRC.

There was no signage at the entrance of the home area which stated what Personal Protective Equipment (PPE) staff were required to wear or donning or doffing signage.

Inspector #522 observed an over bed table with gloves, disinfectant wipes, hand sanitizer

and one face shield outside the entrance to the home area. There was a clear bag of disposal gowns and a laundry bag on the floor.

Inspector #522 asked the AMRC what was in the laundry bag. The AMRC stated reusable gowns were in the bag and acknowledged there should be an additional table for the gowns instead of having them on the floor.

The AMRC informed Inspector #522 that staff were required to wear a gown, face mask, and face shield on the home area and gloves for resident contact and acknowledged there was no signage and should be.

5) During an Infection Prevention and Control (IPAC) tour of the home, Inspector #522 noted signage on the entrance door to the screening area which stated, “For everyone’s safety please maintain social distancing one person at a time at screening table wait your turn outside in vestibule.”

i) On a specific date, while Inspector #522 was being screened in screening area, Staff Member #133 entered the screening area, took their temperature and proceeded to leave the screening area without being screened.

Screener #109 stated only two people were allowed in the screening area, which included the screener.

ii) On a specific date, while Inspector #522 was doffing their PPE in the vestibule the screener unlocked the door and let a visitor into vestibule with Inspector #522.

iii) The following day, while Inspector #522 was doffing their PPE in the vestibule the screener allowed a staff member to enter the vestibule from the screening area.

iv) The following day, upon exiting the home Inspector #522 was told by the screener not to throw out their face shield that they could take it home and reuse it.

As Inspector #522 was doffing their PPE in the vestibule, a person who later identified themselves as Staff Member #134 opened the entrance door to the vestibule to enter the home. When Inspector #522 informed Staff Member #134, who was not wearing a mask, that only one person was allowed in the area at a time, Staff Member #134 questioned who inspector was and asked where it stated only one person was allowed in the vestibule. Inspector informed Staff Member #134 that there was signage on the front of

the entrance door which indicated only one person was allowed in the vestibule at a time. Staff Member #134 was observed outside chatting with someone, neither were masked or socially distant.

v)On a specific date, Inspector #522 observed two staff members at separate times in the vestibule of the home remove their mask, lift the handle on the lid to the garbage bin, dispose of their mask and exit without sanitizing their hands.

When Inspector #522 was in the vestibule doffing their gown, two staff members came into the area together and disposed of their masks and left. There were two staff members noted in the screening area waiting to leave. The screening area had clear signage that only one person was allowed in the screening area at a time, as well as only one person was allowed in the vestibule as this is where staff and visitors would don and doff their PPE.

6) Review of an email sent to staff on May 14, 2021, with the Subject: "Outbreak Update Important Information". Noted a staff member who worked on the first floor had tested positive for COVID-19 and first floor residents were in isolation. The email stated staff were to continue to follow IPAC procedures closely including universal masking, eye protection and hand hygiene.

On a specific date, during the outbreak, Inspector #522 was exiting the parking lot of the home in their vehicle, Inspector #522 observed four staff members and a resident seated outside the first floor west entrance at the front of the home. Three staff were on one side of the entrance seated in a row not socially distant, without their face masks on appropriately. Seated across from them was a staff member who was masked with a resident who was not masked. Inspector #522 notified the Administrator.

Sources
Observations of residents, staff, dining and snack service and screening; review of Steeves and Rozema’s "Hand Hygiene" policy ICM 02-09 with a revision date of April 30, 2020 and “Dining Program” policy RCM 11-14 with a revision date of February 26, 2018; interviews with PSW #102, SG #104, Screener #109, DA #131, RPN #106, the AMRC, MRC and Administrator. [s. 229. (4)]

***Additional Required Actions:***

***CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (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:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**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. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. Pursuant to LTCHA 2007, s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A) The licensee has failed to immediately report emotional abuse of resident #004 to the Director.

Ontario Regulation 79/10 defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Review of the home's investigation notes, indicated during a workplace harassment investigation, Staff Member (SM) #125 told management that 15 days earlier, Personal Support Workers (PSWs) #123 and #124 had made a comment while resident #004 was

coming down the hall that SM #125 should dance. The PSWs made a negative comment about the resident's diagnosis.

In an interview, SM #125 stated on a specific date, PSW #123 and PSW #124 were dancing in the hallway of the home area and PSW #123 had made an inappropriate action. SM #125 stated PSW #123 saw resident #004 was coming down the hall with another staff member and the PSWs told SM #125 to do the same inappropriate action to resident #004. SM #125 stated they were unsure if resident #004 heard the PSWs comment.

SM #125 stated they only reported it to the Manager of Resident Care (MRC) when they reported how they were mistreated by staff as everything else about residents came up at that time.

B) The licensee failed to immediately report verbal and emotional abuse of resident #003 to the Director.

Ontario Regulation 79/10 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

Review of the home's investigation notes, indicated PSW #126 told management that they had seen PSW #124 be verbally abusive to residents, including resident #003. PSW #126 stated that PSW #124 had said behind resident #003's back "Why are you still living?"

PSW #110 told management that eight days earlier, PSW #110 witnessed PSW #124 be verbally abusive to resident #003 when the resident approached the window at the nurses' station to get their attention.

In interviews, both PSW #110 and PSW #126 both acknowledged that they had witnessed PSW #124 be abusive to resident #003 but were not aware of the requirement for mandatory reporting of abuse to the Director.

In an interview, Registered Practical Nurse (RPN) #127 stated they had spoken to PSW #124 in the past regarding how they had spoken with resident #003. RPN #127 stated they did not deem it as something to report as PSW #124 did not respond to resident

#003 that way in RPN #127's presence again.

C) The licensee failed to immediately report verbal abuse of resident #002 to the Director.

During an investigation into a workplace harassment complaint, Personal Support Worker (PSW) #110 stated nine days earlier, PSW #124 had swore at resident #002 when they were getting the resident out of bed with PSW #110.

In an interview, PSW #110 stated they should have reported the incident to management when it happened. PSW #110 stated they were not aware of the requirement for mandatory reporting of abuse to the Director.

Sources:
Critical Incident System (CIS) reports #2872-00009-21, #2872-0000011-21, and #2872-000012-21, the home's investigative notes, residents #002, #003, and #004's clinical records; and interviews with PSW #110, PSW #126, RPN #127, RSA #125, LEW#135, the MRC and Administrator. [s. 24. (1)]

***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 a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,**
**(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;**
**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;**
**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**
**(d) that the changes and improvements under clause (b) are promptly implemented; and**
**(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

In an interview, the Administrator stated they had never done an annual evaluation of their abuse and neglect policy. Inspector #522 reviewed Ontario Regulation 79/10 s. 99 with the Administrator. The Administrator stated they had no idea that requirement was in the Regulations.

Sources:
Interview with the Administrator. [s. 99. (b)]

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

**Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée**

**Issued on this 29th day of June, 2021**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l’inspecteur (No) :** | JULIE LAMPMAN (522), DEBRA CHURCHER (670) |
| **Inspection No. / No de l’inspection :** | 2021_725522_0005 |
| **Log No. / No de registre :** | 025784-20, 005727-21, 006689-21, 007023-21, 007029-21 |
| **Type of Inspection / Genre d’inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 25, 2021 |
| **Licensee / Titulaire de permis :** | S & R Nursing Homes Ltd.<br>265 North Front Street, Suite 200, Sarnia, ON, N7T-7X1 |
| **LTC Home / Foyer de SLD :** | Afton Park Place Long Term Care Community<br>1200 Afton Drive, Sarnia, ON, N7S-6L6 |
| **Name of Administrator / Nom de l’administratrice ou de l’administrateur :** | Jeff Harvey |

To S & R Nursing Homes Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

**Order / Ordre :**

The licensee must be compliant with LTCHA 2007, c.8 s. 5.

Specifically,
A) All staff and visitors must be actively screened for COVID-19 in accordance with the requirements under Directive #3 for Long-Term Care Homes under the LTCHA 2007.
B) Visitors must properly doff their Personal Protective Equipment (PPE), including gowns and face shields.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A) Directive #3 for Long-Term Care Homes (LTCH) under the LTCH Act 2007 dated May 4, 2021, noted "All individuals must be actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the LTCH. For clarity, staff and visitors must be actively screened once per day at the beginning of their shift or visit."

i) On a specific date, when Inspector #522 was in the screening area and was being screened, Staff Member #133 entered the screening area took their temperature and proceeded to exit through the gate from the screening area into the home when Screener #109 stopped them and asked if they had any new symptoms. Staff Member #133 stated they had no change, left and did not finish the screening process.

Screener #109 stated staff were to wait to be screened before entering the

home. Screener #109 stated that Staff Member #133 should not have entered the screening area as only two people were allowed in the screening area at a time.

Review of the home's screening tool sheets for staff over a four day period, noted a temperature was recorded but not all staff members had completed the required screening questions.

Review of Staff Member #133's screening from the day they did not complete screening, noted two of the screening questions had been answered as 'no' when the questions had not been asked.

ii) Review of the 2 East -Somerset screening binder during the home area's COVID-19 outbreak noted, "Staff and Essential Caregivers: Please screen yourself in and out for every shift/visit (record the time, your name, temperature and answer all your questions)".

Review of the 2 East Screening Tools over a two day period, noted not all staff members had answered all the required screening questions.

There were four pages with no date entered. Of those pages, not all staff members answered all the required screening questions and/or took their temperature upon entering the home.

In an interview, the Administrator stated they did not want 2 East staff going through the front with the other staff and had the 2 East staff use a separate entrance and passively screen.

Sources:
Observations of the staff screening process, review of the home's screening tools and interviews with Screener #109, the Assistant Manager of Resident Care (AMRC), MRC and Administrator.

B) During an Infection Prevention and Control tour of the home, Inspector #522 observed an essential caregiver leaving the screening area to enter the vestibule. The essential caregiver had taken their coat from the coat rack in the screening area and put it on over their gown to go into the vestibule to remove

their Personal Protective Equipment (PPE).

C) Directive #3 for Long-Term Care Homes (LTCH) under the LTCH Act 2007 dated May 4, 2021, noted, "All staff and essential visitors are required to wear appropriate eye protection (e.g., goggles or face shield) when they are within 2 metres of a resident(s) as part of provision of direct care and/or when they interact with a resident(s) in an indoor area." Under information and training the directive recommends that "LTCHs must provide all health care workers, other staff, and any essential visitors who are required to wear PPE with information on the safe utilization of all PPE, including training on proper donning and doffing."

On a specific date, while Inspector #522 was doffing their PPE in the vestibule the screener let an essential visitor into the vestibule area. While inspector was leaving the parking lot they observed that the essential visitor had not doffed their face mask and had the reusable face shield hanging around their elbow.

In an interview, the MRC stated essential caregivers had been given face shields to take home since Directive #3 required the use of face shields in the home. The MRC stated the essential caregivers were never educated on how to disinfect and store the face shields.

Inspector #522 received an email forwarded from the Bluewater Health Senior Infection Control Practitioner noting that Public Health Ontario (PHO) had stated from a risk mitigation, the home could train essential caregivers on properly disinfecting the reusable face shield and the face shield should be stored onsite at the home.

Sources:
IPAC tour of the home, observations of visitors; review of Steeves & Rozema's Visitation and Testing policy RCM 05-16 revised May 11, 2021, email correspondence to essential caregivers from the home dated March 24, 2021, April 14, 2021 and May 19, 2021, email correspondence from PHO; interviews with Screener #109, the Bluewater Health Senior Infection Control Practitioner, AMRC, MRC and Administrator.

An order was made by taking the following factors into account:

Severity: The home was in a COVID-19 outbreak and not completing active screening of staff placed residents at actual risk. Also, visitors not doffing their PPE appropriately and taking reusable face shields home without being disinfected placed residents at actual risk.

Scope: This noncompliance was widespread as a staff member was observed not being actively screened and documentation showed that active screening had not been completed on numerous occasions for staff. Observations noted two visitors did not doff their PPE correctly and visitors had not been given education on how to disinfect reusable face shields.

Compliance History: Five written notifications (WNs), four voluntary plans of correction (VPCs) and two compliance orders (COs) were issued to the home related to different sections of the legislation in the past 36 months. (522)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 31, 2021

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre :** 002

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

**Order / Ordre :**

The licensee must be compliant with LTCHA 2007, c.8 s. 6 (7).

Specifically,

A) Ensure resident #001 and all other residents have a falls intervention posted as per their plan of care.
B) Resident #001 and all other residents, who use specific falls interventions, have those interventions in place as per the residents' plan of care.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Review of resident #001's clinical record showed resident #001 had experienced a fall.

Review of resident #001's Post Fall Risk Management, showed that resident #001 had experienced a fall and a specific falls intervention was not in place at the time of the fall.

Review of resident #001's plan of care prior to the fall and current plan of care stated that the resident was to have specific falls interventions in place.

On a specific date, Inspector #670 observed resident #001 seated in their room without two specific falls intervention in place.

B) Review of resident #005's clinical record showed resident #005 had

experienced a fall.

Review of resident #005's Post Fall Risk Management showed that resident #005 had experienced a fall and a specific falls intervention was not in place at the time of the fall.

Review of resident #005's plan of care in place at the time of the fall stated that the resident was to have specific falls interventions in place.

Sources:
Resident #001 and #005 clinical records, observations of resident #001, interview with MRC.

An order was made by taking the following factors into account:

Severity: Residents #001 and #005 suffered actual harm after a fall when their falls interventions were not in place. Resident #001 did not have a falls intervention posted which put them at actual risk as there was nothing to indicate the resident was a falls risk.

Scope: There was a pattern of non-compliance as two out of three residents did not have their falls interventions in place as per their plan of care and during the inspection resident #001 was observed without a falls intervention in place.

Compliance History: One written notification (WN) was issued to the home related to a different subsection of the legislation in the past 36 months. (670)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 31, 2021

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre :** 003

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee must be compliant with LTCHA 2007, c.8 s.19 (1).

Specifically, that all residents are protected from abuse by staff.

**Grounds / Motifs :**

1. The licensee has failed to protect resident #002, #003 and #004 from abuse from Personal Support Workers (PSWs) #123 and PSW #124.

Ontario Regulation 79/10 defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Ontario Regulation 79/10 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

A) During a workplace harassment investigation, Staff Member (SM) #125 told management that Personal Support Workers (PSWs) #123 and #124 had made a comment while resident #004 was coming down the hall that SM #125 should dance and made a negative comment about resident #004's diagnosis.

A review of PSW #124's employee record noted on several occasions PSW #124 had been verbally abusive and inappropriate with residents.

In an interview, SM #125 stated on a specific date, PSW #123 and PSW #124 were dancing in the hallway of the home area and PSW #123 had made an inappropriate action. SM #125 stated PSW #123 saw resident #004 was coming down the hall with another staff member and the PSWs told SM #125 to do the same inappropriate action to resident #004. SM #125 stated they were unsure if resident #004 heard the PSWs comment.

B) During the same investigation, Personal Support Worker (PSW) #110 told management that PSW #124 had verbally abused resident #002 when they were getting the resident out of bed with PSW #110. PSW #110 stated resident #002 probably heard the comment as PSW #124 was right beside resident #002 when they made the comment, but the resident did not respond or react.

In an interview, PSW #110 stated when working with PSW #124 on a specific date, PSW #124 swore at resident #002. PSW #110 stated they did not say anything to PSW #124 or report the incident to management until they were interviewed as part of a workplace harassment complaint.

C) Personal Support Worker (PSW) #110 also told management that on the following day, while sitting at the nurses station with Registered Practical Nurse (RPN) #127 and PSW #124, resident #003 came to the nurses' station window and PSW #124 was verbally abusive to the resident.

In an interview, PSW #110 stated when working with PSW #124, resident #003 kept coming to the nurses' station and PSW #124 got annoyed. PSW #110 stated RPN #127 told PSW #124 that they needed to be nice to resident #003.

In an interview, PSW #126 stated when they had worked with PSW #124 and were leaving resident #003's room, PSW #124 stated to PSW #126 that resident #003 should just die. PSW #126 stated they did not think resident #003 would have heard the comment.

In an interview, RPN #127 stated they did not hear exactly what PSW #124 stated to resident #003 at the nurses station. RPN #127 stated they had spoken to PSW #124 in the past regarding how they had spoken with resident #003. RPN #127 stated they did not feel that was appropriate.

Sources:
Critical Incident System (CIS) reports #2872-00009-21, #2872-000011-21 and #2872-000012-21, the home's investigative notes, residents #002, #003 and #004's clinical records and PSW #124's employee record; and interviews with PSW #110, PSW #126, RPN #127, SM #125, LEW#135, the MRC and Administrator.

An order was made by taking the following factors into account:

Severity: Residents #002, #003 and #004 suffered actual verbal and/or emotional abuse from PSWs #123 and/or PSW #124.

Scope: The area of non-compliance was widespread; three out of three abuse investigations reviewed noted all three residents suffered actual abuse from the PSW(s).

Compliance History: A compliance order was previously issued for this section of the LTCHA 2007 on November 25, 2020, during inspection #2020_778563_0032.
(522)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 30, 2021

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre :** 004

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

**Order / Ordre :**

The licensee must be compliant with LTCHA 2007, c. 8, s. 20 (1).

Specifically,
A) All staff must comply with the home's abuse and neglect policy.
B) All staff on a specific home area will receive training on the home's abuse and neglect policy and mandatory reporting of abuse. A record will be kept of the training, the date the training occurred and the names of staff members in attendance.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of Steeves & Rozema's "Resident Abuse and Neglect" policy noted in part:
"Any employee or volunteer who witness an incident of resident abuse, or has knowledge of an incident that constitutes resident abuse or neglect, will intervene and implement strategies to ensure the safety of every resident and staff member."

"Any employee or volunteer who witness an incident of resident abuse, or has knowledge of an incident that constitutes resident abuse or neglect, will immediately inform the Administrator, Manager Resident Care (MRC), or in their absence, the Charge Nurse/delegate in the home, of any incident of suspected or witnessed abuse. The Charge Nurse/Delegate will then immediately notify the

Administrator or MRC."

A) In an interview Staff Member (SM) #125 stated PSW #124 and PSW #123 were dancing and PSW #123 made an inappropriate action. SM #125 stated PSW #123 saw resident #004 was coming down the hall with a staff member the PSWs told SM #125 to do the same inappropriate action to resident #004.

SM #125 stated they did not do anything other than tell the PSWs that they would not do the inappropriate action, nor did they report the incident when it occurred. They had only reported the incident to the Manager of Resident Care when they were being interviewed as part of a separate investigation, which was 15 days after the incident.

B) In an interview, PSW #110 stated when PSW #124 swore at resident #002 they did not say anything to PSW #124 or resident #002. PSW #110 also told management that the following shift, while sitting at the nurses' station with Registered Practical Nurse (RPN) #127 and PSW #124, resident #003 approached the window at the nurses' station to get their attention and PSW #124 was verbally abusive to resident #003.

PSW #110 stated they reported the incidents to management over a week later. PSW #110 stated they should have reported the incidents when they happened but stated they had reported a previous staff member and felt nothing had been done.

C) During an investigation into a workplace harassment complaint, PSW #126 told management that they had seen PSW #124 be verbally abusive to residents, including resident #003.

Sources:
Critical Incident System (CIS) reports #2872-000009-21, #2872-0000011-21, and #2872-0000012-21, the home's investigative notes, residents #002, #003, and #004's clinical records; interviews with PSW #110, PSW #126, RPN #127, SM #125, the MRC and Administrator.

An order was made by taking the following factors into account:

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Severity: There was actual harm to residents as staff had witnessed verbal and emotional abuse of residents but did not report it to management or intervene when the incidents occurred.

Scope: The area of non-compliance was widespread; three out of three abuse investigations reviewed noted staff did not report witnessed incidents of resident abuse or intervene on the resident's behalf.

Compliance History: A voluntary plan of correction (VPC) related this area of legislation was issued on October 28, 2019, during inspection #2019_819524_0008. (522)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 31, 2021

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre :** 005

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 75. (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2); 2015, c. 30, s. 24 (1).

**Order / Ordre :**

The licensee must be compliant with LTCHA 2007, c. 8, s. 75. (2).

Specifically,
A) As per Directive #3 for LTCHs under the LTCHA 2007, Personal Support Workers (PSWs) #128, #129 and #130 and Security Guard #104 shall sign a declaration disclosing any charges and convictions for offences.
B) All other staff members previously hired during the pandemic shall sign a declaration disclosing any charges and convictions for offences, if there was no police check obtained upon hire.
C) Prior to their first day of work, all staff members hired during the pandemic shall sign a declaration disclosing any charges and convictions for offences, if no police check is obtained upon hire.
D) Should PSWs #128, #129 and #130 and Security Guard #104 and any other staff member hired while the pandemic was declared, continue to be employed at the home after these regulations are revoked, a police record check must be obtained.

**Grounds / Motifs :**

1. The licensee has failed to ensure that police record checks were conducted prior to hiring staff members.

LTCHA 2007 c.8 defines staff as "persons who work at the home pursuant to a contract or agreement with the licensee, or pursuant to a contract or agreement between the licensee and an employment agency or other third party."

Directive #3 for Long-Term Care Homes (LTCH) under the LTCH Act, 2007 dated March 20, 2020, noted the following amendments to Ontario Regulation

79/10:

"Before a staff member is hired or a volunteer is accepted by a licensee, the licensee must require that the staff member or volunteer provide the licensee with a signed declaration disclosing specified charges and convictions for offences since the date the person's last police record check was conducted, or if no such police record check has been conducted, of all occurrences."

Review of Personal Support Worker (PSW) #123's employee record noted that PSW #123's police check was dated two years prior to their hire date.

On a specific date, Security Guard (SG) #104 was observed providing 1:1 support to a resident. Review of SG #104's employee file noted there was no police check or signed declaration disclosing specified charges and convictions for offences on file.

Review of employee files of new agency hires for PSW #128, #129, and #130 noted no police check on file for PSW #128 and #130 and PSW #129's police check was outdated. There was no signed declaration disclosing specified charges and convictions for offences on file.

Sources:
Review of Critical Incident System report #2872-000009-21, the home's "Police Record Check" policy #7.1.38 with a revision date of April 14, 2021, employee files for PSWs #123, #128, #129 and #130 and SG #104 and interview with the Office/Staffing Coordinator and the Administrator.

An order was made by taking the following factors into account:

Severity: There was actual harm to residents as PSW #123 who was involved in an incident of resident of emotional abuse did not have a valid police check completed. There was also actual risk to residents as the home did not have a current police check or signed declaration declaring any convictions or offences on file for newly hired direct care staff.

Scope: The area of non-compliance was widespread; five employee files were reviewed and all five did not have current police checks or a signed declaration

of any convictions or offences.

Compliance History: Five written notifications (WNs), four voluntary plans of correction (VPCs) and two compliance orders (COs) were issued to the home related to different sections of the legislation in the past 36 months. (522)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 30, 2021

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre :** 006

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

**Order / Ordre :**

The licensee must be compliant with LTCHA 2007, c. s. 76. (4).

Specifically,

A) All staff must receive training on the Residents' Bill of Rights, the duty to make mandatory reports under section 24, and whistle-blowing protections.
B) All staff must receive training on infection prevention and control practices (IPAC) related to COVID-19, including but not limited to: social distancing, universal masking, breaks, screening measures, and entering and exiting the home.
C) A record must be kept of the training, including the dates of the training and the staff members who completed the training.

**Grounds / Motifs :**

1. The licensee has failed to ensure that all staff received training in infection prevention and control related to COVID-19.

Ontario Regulation 79/10 s. 219 (1) requires annual training in relation to infection prevention and control.

Throughout the inspection some staff members were observed not social distancing, not wearing their mask appropriately or not at all, and not sanitizing their hands after doffing their mask.

A staff member was also observed not completing mandatory active screening for COVID-19 upon entry to the home.

Review of the home's screening records noted not all staff members were answering all required screening questions.

In an interview the Assistant Manager of Resident Care (AMRC) stated staff were to read the required COVID-19 education and sign that they had read the information and then this was entered into Surge Learning.

Review of the home's Infection Prevention and Control training for all departments related to COVID-19 in Surge Learning noted the following:

1) Coronavirus dated February 14, 2020 - 24 out of 165 (14.5%) completed.

2) COVID-19 FAQ  dated March 6, 2020 – 37 out of 165 (22.4%) completed.

3) COVID-19: Infection Control Directive and Policy 7.1.72 COVID-19 Entering and Leaving the Workplace dated March 31, 2020 – 34 out of 168 (20.2%) completed.

4) Pandemic Safety Measures – reminder memo dated July 9, 2020 - 58 out of 165 (35.2%) completed.

5) COVID-19 Protocols Refresher dated December 3, 2020 -38 out of 165 - (23.0%) completed.

In an interview, the Manager of Resident Care (MRC) stated the previous Resident Care Coordinator was responsible for the education and tracking.

The MRC stated they also sent information out by email and posted in the message board in Point Click Care but were unable to provide inspector any further education or training from 2020.

Sources:
Review of the home's training records, interviews with the AMRC, MRC and Administrator.

2. The licensee has failed to ensure that all staff had received retraining annually

related to the following:
• The Residents' Bill of Rights;
• The duty to make mandatory reports under section 24;
• The whistle-blowing protections.

Review of the home's 2020 Surge Learning noted the following
70 out of 138 (50.7%) of staff completed Critical Incidents/Mandatory Reporting/Whistleblowing protection training.
94 out of 138 (68.1%) of staff completed Resident Bill of Rights training.

Sources:
Review of the home's "Team Member Education" policy #09-01 with a revision date of December 28, 2017, 2020 Surge Learning training, interviews with the MRC and Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk to residents as the home was in a COVID-19 outbreak and not all staff had completed the home's IPAC training on COVID-19. There was actual risk to residents as not all staff had completed training on the Residents' Bill of Rights and mandatory reporting and two staff members who witnessed actual abuse were not aware of the requirement of immediate reporting of abuse to the Director.

Scope: The area of non-compliance was widespread as most of the home's staff had not completed the required training.

Compliance History: Five written notifications (WNs), four voluntary plans of correction (VPCs) and two compliance orders (COs) were issued to the home related to different sections of the legislation in the past 36 months. (522)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 30, 2021

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre :** 007

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

**Order / Ordre :**

The licensee must be compliant with O. Reg. 79/10 s. 8. (1)(b).

Specifically,
A) The home will complete education with all registered staff members related to the home's head injury routine policy.
B) A record must be kept of the training, including the dates of the training and the staff members who completed the training.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the home's Fall Prevention and Management Program policy was complied with.

A) The home's policy titled Fall Prevention and Management Program RCM 10-02-01, revision date May 8, 2019 stated "A head injury protocol will be followed when a resident receives an injury to the head, a suspected injury to the head or an unwitnessed fall".

During an interview with the MRC, the Head Injury Routine (HIR) form was reviewed and the MRC confirmed that the policy of the home was to complete HIR assessments every half hour for four assessments followed by every hour for four assessments followed by every two hours for four assessments then on the day and evening shift for two days.

Risk management notes stated that resident #001 had two unwitnessed falls.

Review of resident #001's HIR documentation showed that resident #001 did not have a HIR assessment completed in full after each fall.

B) Risk management note stated that resident #006 had an unwitnessed fall.

Review of resident #006's HIR documentation showed that resident #006 did not have a HIR assessment completed in full after the fall.

C) Risk management note stated that resident #007 had a fall and stated that they hit their head.

Review of resident #007's HIR documentation showed that resident #007 did not have a HIR assessment completed in full after the fall.

Sources:
Review of the homes falls prevention and HIR policy, review of residents #001, #006 and #007 HIR documentation, and interview with the MRC.

An order was made by taking the following factors into account:

Severity: Head Injury Routine assessments were incomplete for residents #001, #006 and #007 after they had a fall. This put the residents at actual risk as staff had the potential to miss post fall injuries.

Scope: The scope of this non-compliance was widespread as the home's Fall Prevention and Management Program policy was not complied for all three residents reviewed.

Compliance History: A compliance order (CO) was previously issued to this section of O. Reg 79/10 on September 10, 2020, during inspection #2020_648741_0011.
(670)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Sep 30, 2021

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre :** 008

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

**Order / Ordre :**

The licensee must be compliant with O. Reg. 79/10, s. 97 (2).

Specifically,
A) That residents #002, #003 and #004's substitute decision makers are notified of the results of the home's investigations into the abuse of the individual resident and the notification is documented.
B) Immediately after the completion of an abuse investigation for any resident, the resident's SDM is notified of the results of the home's investigation.

**Grounds / Motifs :**

1. The licensee has failed to ensure that residents #002, #003 and #004's Substitute Decision Makers (SDMs) were notified of the results of an abuse investigation immediately upon the completion of the investigation.

A) Personal Support Worker (PSW) #110 had reported to management that they had witnessed PSW #124 verbally abuse resident #002.

B) Personal Support Worker (PSW) #110 had reported to management that they had witnessed PSW #124 verbally abuse resident #003.

C) On a specific date, the home initiated an investigation into an allegation of emotional abuse towards resident #004 from Personal Support Workers #123 and #124.

Review of resident #002, #003 and 004's progress notes indicated their SDMs had not been updated on the results of the home's investigation into the abuse.

In an interview, the Manager of Resident Care (MRC) stated they had not informed resident #002, #003 and #004's SDMs of the results of the investigation.

Sources:

Review of Critical Incident Report (CIS) reports #2872-00009-21, #2872-000011 -21, and #2872-000012-21, the home's investigative notes, residents #002, #003 and #004's clinical records and interview with the MRC.

An order was made by taking the following factors into account:

Severity: There was no actual risk to the residents by not notifying their SDM.

Scope: This noncompliance was widespread; of the three abuse investigations reviewed, all three resident's SDMs were not notified of the results of the home's investigation which indicated abuse had occurred.

Compliance History: Five written notifications (WNs), four voluntary plans of correction (VPCs) and two compliance orders (COs) were issued to the home related to different sections of the legislation in the past 36 months. (522)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 31, 2021

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre :** 009

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

**Order / Ordre :**

The licensee must be compliant with O. Reg. 79/10 s. 221. (2).

Specifically,
A) All staff who provide direct care to residents must be trained on abuse recognition and prevention.
B) A record will be kept of the training, including the dates of the training and all staff who completed the training.

**Grounds / Motifs :**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee failed to ensure that all staff who provided direct care to residents, received training relating to abuse recognition and prevention annually.

Review of the home's "Team Member Education noted annual abuse education was in person for all staff.

On May 27, 2021, in an interview, the Manager of Resident Care (MRC) stated the home had not completed in person abuse training in 2020 due to the pandemic and there was no additional staff training completed in place of the in person abuse training.

Sources:
Review of the home's "Team Member Education" policy #09-01 with a revision date of December 28, 2017, interviews with the MRC and Administrator.

An order was made by taking the following factors into account:

Severity: There was actual harm to residents as staff failed to recognize and report verbal and emotional abuse of residents.

Scope: The area of non-compliance was widespread as direct care staff did not receive training on abuse recognition and prevention in 2020.

Compliance History: Five written notifications (WNs), four voluntary plans of correction (VPCs) and two compliance orders (COs) were issued to the home related to different sections of the legislation in the past 36 months (522)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 30, 2021

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre :** 010

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

**Order / Ordre :**

The licensee must be compliant with O. Reg. 79/10, s. 229 (4).

Specifically,
A) Complete and document weekly audits of staff and resident hand hygiene at snack and meal times.
B) Complete and document weekly audits of the screening area and vestibule to ensure staff/visitors are social distancing when entering and exiting the home.
C) Complete and document weekly audits of staff break areas to ensure maximum capacity of staff and social distancing.
D) Complete and document weekly audits to ensure staff are wearing their masks appropriately.
E) Audits shall be completed for 6 months or until compliance is achieved.
F) Keep documentation of corrective actions taken for any deficiencies found on the weekly audits.

**Grounds / Motifs :**

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

1) During observations of a home area with the Assistant Manager of Resident Care (AMRC), Inspector #522 observed Personal Support Worker (PSW) #102 pour a drink and give it to a resident and touch the resident on the back. The PSW returned to the snack cart, wheeled it down the hall and proceeded to pour another resident a drink. PSW #102 did not sanitize their hands in between residents and inspector observed there was no hand sanitizer on the snack cart.

The Assistant Manager of Resident Care (AMRC) stated to PSW #102 that there was to be hand sanitizer on the snack cart.

Review of Steeves and Rozema's "Hand Hygiene" policy noted hand hygiene should be performed before initial contact with each resident or items in their environment and after contact with a resident or their environment.

In an interview, the AMRC stated staff should sanitize their hands before and after each contact with a resident during snack service and staff should have hand sanitizer on the snack cart for easy access to sanitizer.

2) During an Infection Prevention and Control tour of the home, Inspector #522 observed staff bringing residents down for lunch and sitting them at their table in the dining room.

Inspector #522 observed Security Guard (SG) #104 assist a resident from a common area to the dining room on a home area. SG #104 assisted the resident to sit down at a table and gave them a clothing protector but did not assist the resident to wash their hands.

In an interview, SG #104 stated they were working 1:1 with the resident and they did not wash the resident's hands before or after meals.

In an interview, PSW #102 stated they were uncertain if they should sanitize residents' hands before meals, but they did wash residents' hands after meals.

Review of Steeves & Rozema "Dining Program" policy noted "All residents will be provided with the opportunity to wash/wipe their hands and face before and after his/her meals."

In an interview, AMRC stated all residents should have their hands washed before and after meals.

3) i) On a home area, Inspector #522 observed two staff seated in the Resident Care Centre area through the window. Staff were seated chatting and one staff member had their mask pulled down below their chin.

ii) Inspector observed a designated break room for staff due to the COVID-19 outbreak on the home area. Inspector observed two staff members seated at

separate tables socializing without masks on.

iii) On a home area, inspector observed Dietary Aide #131 in the dining area with their mask only covering their mouth. Inspector asked DA #131 if they were aware they were to wear their mask over their nose. DA #131 did not say anything and pulled their mask up over their nose.

4) Inspector #522 observed a home area which was in a COVID-19 outbreak with the AMRC.

There was no signage at the entrance of the home area which stated what Personal Protective Equipment (PPE) staff were required to wear or donning or doffing signage.

Inspector #522 observed an over bed table with gloves, disinfectant wipes, hand sanitizer and one face shield outside the entrance to the home area. There was a clear bag of disposal gowns and a laundry bag on the floor.

Inspector #522 asked the AMRC what was in the laundry bag. The AMRC stated reusable gowns were in the bag and acknowledged there should be an additional table for the gowns instead of having them on the floor.

The AMRC informed Inspector #522 that staff were required to wear a gown, face mask, and face shield on the home area and gloves for resident contact and acknowledged there was no signage and should be.

5) During an Infection Prevention and Control (IPAC) tour of the home, Inspector #522 noted signage on the entrance door to the screening area which stated, "For everyone's safety please maintain social distancing one person at a time at screening table wait your turn outside in vestibule."

i) On a specific date, while Inspector #522 was being screened in screening area, Staff Member #133 entered the screening area, took their temperature and proceeded to leave the screening area without being screened.

Screener #109 stated only two people were allowed in the screening area, which included the screener.

ii) On a specific date, while Inspector #522 was doffing their PPE in the vestibule the screener unlocked the door and let a visitor into vestibule with Inspector #522.

iii) The following day, while Inspector #522 was doffing their PPE in the vestibule the screener allowed a staff member to enter the vestibule from the screening area.

iv) The following day, upon exiting the home Inspector #522 was told by the screener not to throw out their face shield that they could take it home and reuse it.

As Inspector #522 was doffing their PPE in the vestibule, a person who later identified themselves as Staff Member #134 opened the entrance door to the vestibule to enter the home. When Inspector #522 informed Staff Member #134, who was not wearing a mask, that only one person was allowed in the area at a time, Staff Member #134 questioned who inspector was and asked where it stated only one person was allowed in the vestibule. Inspector informed Staff Member #134 that there was signage on the front of the entrance door which indicated only one person was allowed in the vestibule at a time. Staff Member #134 was observed outside chatting with someone, neither were masked or socially distant.

v)On a specific date, Inspector #522 observed two staff members at separate times in the vestibule of the home remove their mask, lift the handle on the lid to the garbage bin, dispose of their mask and exit without sanitizing their hands.

When Inspector #522 was in the vestibule doffing their gown, two staff members came into the area together and disposed of their masks and left. There were two staff members noted in the screening area waiting to leave. The screening area had clear signage that only one person was allowed in the screening area at a time, as well as only one person was allowed in the vestibule as this is where staff and visitors would don and doff their PPE.

6) Review of an email sent to staff on May 14, 2021, with the Subject: "Outbreak Update Important Information". Noted a staff member who worked on the first

floor had tested positive for COVID-19 and first floor residents were in isolation. The email stated staff were to continue to follow IPAC procedures closely including universal masking, eye protection and hand hygiene.

On a specific date, during the outbreak, Inspector #522 was exiting the parking lot of the home in their vehicle, Inspector #522 observed four staff members and a resident seated outside the first floor west entrance at the front of the home. Three staff were on one side of the entrance seated in a row not socially distant, without their face masks on appropriately. Seated across from them was a staff member who was masked with a resident who was not masked. Inspector #522 notified the Administrator.

Sources
Observations of residents, staff, dining and snack service and screening; review of Steeves and Rozema's "Hand Hygiene" policy ICM 02-09 with a revision date of April 30, 2020 and "Dining Program" policy RCM 11-14 with a revision date of February 26, 2018; interviews with PSW #102, SG #104, Screener #109, DA #131, RPN #106, the AMRC, MRC and Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk to residents as the home was currently in a COVID-19 outbreak during the inspection.

Scope: This noncompliance was widespread as on numerous occasions staff were observed not to be socially distant in the screening and vestibule area as well as outside the home, staff were observed together without wearing masks or staff were observed not wearing their mask appropriately, a staff member was observed not sanitizing their hands while giving out snack and two staff acknowledged that they did not wash residents' hands before and after meals.

Compliance History: Five written notifications (WNs), four voluntary plans of correction (VPCs) and two compliance orders (COs) were issued to the home related to different sections of the legislation in the past 36 months. (522)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Aug 31, 2021

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 25th day of June, 2021**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Julie Lampman

**Service Area Office /**
**Bureau régional de services :** London Service Area Office