Ontario

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

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

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: April 17, 2023	
Original Report Issue Date: April 3, 2023	
Inspection Number: 2023-1196-0002 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: The Royale Development GP Corporation as general partner of The Royale Development	
Long Term Care Home and City: Bloomington Cove Care Community, Stouffville	
Amended By Laura Crocker (741753)	**Inspector who Amended Digital Signature** Laura L Crocker Digitally signed by Laura L Crocker Date: 2023.04.17 18:30:03 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect a change to Compliance Order #005 part two added designate for hand hygiene auditing, as requested by the home. Compliance Order #005 part three and four amended to reflect a correction from five home areas to four home areas.

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Lead Inspector Laura Crocker (741753)	**Additional Inspector(s)** Asal Fouladgar (751)
Amended By Laura Crocker (741753)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 13, 14, 15, 16, 21, 22, 24, 27, 28, 2023 and March 1, 2, 3, 6, 7, 2023.
The inspection occurred offsite on the following date(s): February 17, 23, 2023.

The following intake(s) were inspected:

- Intake #00001131 [CIR #2697-000003-22], Intake #00002879 [CIR #2697-000002-22, Intake #00003119 [CIR #2697-000009-22], Intake #00005353 [CIR #2697-000021-22], Intake #00013257 [CIR #2697-000037-22] related to resident care and support services.
- Intake #00017647, complaint related to resident care and support services.
- Intake #00003750 [CIR #2697-000025-22], Intake #00011660 [CIR #2697-000026-22], Intake #00008251 [CIR #2697-000029-22], Intake #00007827 [CIR #2697-000028-22], Intake #00008674 [CIR #2697-000032-22] related to responsive behaviours
- Intake #00005832 [CIR #2697-000027-22], Intake #00008056 [CIR #2697-000033-22], Intake #00008496 [CIR #2697-000030-22], Intake #00013838 [CIR #2697-000039-22] related to prevention of abuse and neglect.
- Intakes #00006259, and #00007383, complaint related to prevention of abuse and neglect, staffing, housekeeping, and Infection Prevention and Control (IPAC).
- Intake #00006336, complaint related to IPAC.
- Intake #00009288, complaint related to staffing.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Recreational and Social Activities

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 36

The licensee failed to ensure that staff used safe transferring technique when assisting a resident after a fall.

Rationale and Summary

The home submitted a Critical Incident Report (CIR) to the Ministry of Long-Term Care (MLTC) related to a fall.

The resident's clinical records indicated that they were at high risk for falls due to medical conditions and previous falls with injury. A clinical record documented by a Registered Practical Nursing (RPN) student indicated the resident was on the floor and two staff assisted the resident back to bed.

The home's policy titled "Zero Lift & Protocol, IV-M-10.10", directed staff to conduct all resident lifting with the use of mechanical lift devices in accordance with the plan of care/service plan.

A Personal Support Worker (PSW) and registered staff stated that when they found the resident on the floor beside their bed, they did not use a mechanical lift to transfer the resident back to their bed. Instead, they lifted the resident and transferred them to bed with the help of three staff.

The Assistant Director of Care (ADOC) confirmed that the staff did not use safe transferring technique when they did not use a mechanical lift to transfer the resident back to their bed.

Failure to transfer a resident from the floor to their bed without using a mechanical lift, increases the risk of further injury to the resident.

Sources: Resident's clinical records, the home's policy titled "Zero Lift & Protocol, interviews with staff. [751]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 49 (2)

The licensee failed to ensure that a post-fall assessment was conducted using a clinically appropriate assessment instrument when a resident had an unwitnessed fall.

Rationale and Summary
The home submitted a CIR to the MLTC related to a resident a fall with injury.

A progress note documented by a student RPN approximately one week prior to the resident's injury, indicated the resident moved independently from their bed to the floor. No fall incident report or post-fall assessment was documented related to this progress note.

Two staff stated that the resident was found on the floor on a pillow, and they just slid the resident back to their bed. The registered staff reported they did not consider this incident as a fall because the resident's bed was at the lowest position hence, they did not follow the home's falls prevention policy in completing the internal incident report and post-fall assessment tool.

In the attachment titled "Risk Factors & Related Interventions" in the home's falls prevention policy, a fall was defined as "An event that results in a person coming to rest inadvertently on the ground, floor, or other lower level, with or without injury".

The ADOC confirmed that according to the home's investigation, the documented progress note was considered an unwitnessed fall and the staff did not follow the home's falls prevention policy as there was no falls documentation, post-fall assessment, or incident management note related to this incident.

Failure to implement the falls prevention policy by staff, would pose a risk to the safety and well-being of the resident when there was no specific post-fall assessment and follow-up implemented.

Sources: The home's policy titled" Falls prevention & Management, the resident's clinical records, the home's investigation notes, and interviews with staff.
[751]

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5

The licensee has failed to ensure that spa room doors were locked when they were not being supervised by staff.

Rationale and Summary

A complaint was received regarding care in the spa rooms while the doors were opened.

Inspectors #751 and #741753 observed the spa room door was left open on a Resident Home Area (RHA). The spa room had razors in the cupboard. The ADOC stated the spa room door should have been closed and locked on its own and they were going to request maintenance staff to fix the door. On the same day, the Inspectors observed a spa room door was left open in an RHA with razors in a linen cart.

Registered staff reported the spa room door should be closed at all times.

On another occasion Inspector #751 observed the spa room door was left open in the same RHA. Registered staff reported they had forgot to close the spa room door and confirmed the spa room door should be closed at all times.

Failing to close and lock the spa room doors increased safety risk to the residents as sharps were easily accessible.

Sources: Observations and interviews with staff.
[741753]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that a resident's written plan of care provided clear direction to staff with regards to oral care.

Rationale and Summary

A complaint was received regarding a resident needing assistance with oral care.

The resident's clinical records indicated that they had a medical condition and mobility impairment and required staff to provide the resident assistance with oral care.

Interviews with four PSW's staff indicated different approaches to providing oral care to the resident. The registered staff acknowledged that the resident's written plan of care did not provide clear direction to the staff regarding the supplies and equipment to be used for the resident's oral hygiene.

There was risk to the well-being of the resident when staff used different approaches in providing oral care to the resident considering the resident's medical diagnosis and physical limitations.

Sources: Observations, the resident's clinical records, interviews with staff.
[751]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that a resident's test kit was ordered in time as per physician's order noted in the resident's plan of care.

Rationale and Summary

A complaint was received regarding a resident's personal care.

A resident's clinical records indicated that there were concerns related to the resident's personal care, and the physician ordered a test kit to determine the presence of infection. According to the progress notes, the test that was to be ordered from the lab by a member of the home's management team. Further review of the resident's clinical records indicated that the specimen was collected, and the results received eleven days later, which indicated no infection.

The Director of Care (DOC) confirmed that test was not ordered in a timely manner according to the physician's order.

There was a risk to the resident's well-being when the test was not ordered on time which delayed the process of diagnosing and treating the resident's condition.

Sources: CIR, the resident 's clinical records, and interview with the DOC.
[751]

WRITTEN NOTIFICATION: Personal items and personal aids

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)

1.The licensee has failed to ensure each resident of the home has their personal items labelled.

Rationale and Summary
A complaint was received indicating toiletry products were not individualized when staff provided care to the residents.

The Inspectors made observations on two RHAs. On one RHA, unlabeled nail clippers were observed in a wall mounted cupboard in the spa room. On the same day, an unlabeled brush and nail clippers were observed in the spa room on a different RHA. Two PSW staff confirmed the nail clippers, and the brush should have been labeled.

A PSW was observed exiting a resident's room with toiletries supplies and placing the supplies in a caddy on a clean linen cart outside the resident's room. The PSW confirmed the unlabeled toiletries were not the resident's and the items were used to provide care to residents on the unit. A hairbrush was also in

the caddy, with an illegible label. The PSW reported the brush did not belong to the resident and should not have been in the caddy.

A caddy with toiletry supplies was observed on a clean linen cart inside a resident's room. Two brushes, residents' personal toiletries and the home's supply of toiletries were observed unlabeled in the caddy on the clean linen cart. The PSW reported some of the unlabeled personal toiletries, perfumes, deodorants, and a Vaseline container belonged to different residents on the unit and those toiletries needed to be put back in the residents' drawer. The PSW reported one of the unlabeled brushes belonged to one of the residents in the room and the other brush belonged to another resident in a different room and were on the caddy to be cleaned.

The PSW confirmed the home's toiletries supplies used for resident care were not individualized to each resident and agreed the toiletries should have been labeled. The PSW reported it was the IPAC lead who was responsible for labeling.

The IPAC lead reported that they were not responsible for labeling the residents personal items and it was the PSWs' responsibility. The IPAC lead agreed that toiletry items should have been labeled and individualized for each resident.

The DOC confirmed that the home's toiletries supplies, and the residents' personal items are to be individualized and labeled.

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

Sources: Observation, interviews with the IPAC lead, and staff.
[741753]

2. The licensee failed to ensure that two resident's personal items were labelled.

Rationale and Summary

During observations by Inspectors into a resident's shared washroom, multiple toiletries were noted on different sides of the washroom and none of them were labelled with the residents' names.

Two PSWs explained to the Inspectors which items belonged to which resident and acknowledged that the residents' belongings were supposed to be labelled with their names as the residents resided in a shared room.

There were risks to the safety of the residents when their personal items were not labelled.

Sources: Observations, interviews with staff.
[751]

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that strategies were developed and implemented for a resident to respond to their aggressive behaviour towards co-residents and provide strategies to the staff during care.

Rationale and Summary

A CIR was submitted related to resident to resident physical abuse.

The CIR indicated a resident was physically aggressive towards a co-resident when they were leaving the common room. Three PSWs reported the resident's responsive behavior was physical aggression when co-residents entered their personal space.

The resident's progress notes indicated they had periods of verbal and physical aggression during care. Three PSW staff and one registered staff confirmed the same. The inspector reviewed two months of the resident's clinical records which further indicated the resident's progressive physical aggressions towards co-residents. The care plan was not updated with strategies to manage the resident's physical aggression towards co-residents until six weeks later. The ADOC agreed the care plan should have been updated sooner with the identified triggers and interventions to manage the resident's responsive behavior and physical aggressions.

During the inspection, the resident's plan of care was updated with interventions to manage the resident's responsive behaviours during care. The Behavioural Supports Ontario (BSO) lead agreed the care plan should have been updated prior to February 23, 2023, to include interventions to manage the resident responsive behaviors during care provision.

When the care plan was not updated with strategies to manage the resident's responsive behaviors it increased the risk of injury to the resident, co-residents, and staff.

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

WRITTEN NOTIFICATION: Dining and snack service

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

Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

The licensee failed to ensure that a resident was provided with a feeding device required to safely eat or drink.

Rationale and Summary

The home submitted a CIR indicating a resident was being fed by registered staff using a feeding device without a doctor's order or a dietary referral.

The resident's clinical records indicated that the registered staff spoke to the resident's substitute decision maker (SDM) and received their consent in feeding the resident with the feeding device, then they updated the resident's written plan of care accordingly.

A PSW and a RPN stated they never received any communication from the registered staff regarding feeding the resident via the feeding device. The Registered Dietitian (RD) confirmed that there was nutritional risk when the resident was fed using the feeding device and it required a referral to them for further assessment. The RD further stated that they never received a referral regarding this matter and they accidently discovered the resident was being fed this way when they were reviewing the resident's written plan of care.

The ADOC stated that the registered staff did not use a safe technique for feeding the resident and they should have made a dietary referral when the resident was at nutritional risk.

There was moderate risk to the resident's safety and well-being when the registered staff fed the resident using the feeding device as it would put them at risk of choking.

Sources: CIR, resident's clinical records, interviews with staff.
[751]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 3. iv.

The licensee failed to include the names of family members/SDMs who were contacted related to an alleged incident of neglect in a CIR.

Rationale and Summary

A CIR was submitted to the Director, regarding multiple residents' neglect as continence care was not provided to them by an agency night PSW.

The response documented in the CIR regarding if the family members contacted was "No". However, for the reason for contact, it was documented that "POAs for all residents involved contacted and informed of situation". There was no family members' name or SDM names noted in the CIR.

The DOC stated that they contacted all the residents' SDMs regarding this incident however they did not provide any documentations to Inspectors #751 and #741753 to indicate who were contacted. The involved residents' clinical records did not indicate any documentation regarding the same.

Sources: CIR, resident's clinical records, interview with the DOC.
[751]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

1. The licensee failed to ensure that a resident's drugs were stored in an area which was secure and locked.

Rationale and Summary
During an observation by Inspectors, two tubes of medication tubes labelled with the medication name and the resident's name, were noted on their washroom counter.

The resident's clinical records indicated that their prescribed medication was discontinued six months prior.

A PSW stated that they did not know why the medication tubes were there and that they were not applying those drugs to the resident. A registered staff acknowledged that the resident's prescribed medication tubes were supposed to be placed in a secure and locked area designated for drugs which was the treatment room. The registered staff stated they had removed and discarded the medication tubes upon being informed by the PSW.

There was moderate risk to the safety of the residents with cognitive impairments when such drugs were not placed in a locked area.

Sources: Observations, interviews with registered staff and other staff.
[751]

2.The licensee failed to ensure that a resident's drugs were stored in an area which was secure and locked.

Rationale and Summary

During this inspection, Inspectors #751 observed two containers of prescribed medication creams labelled with the resident's name placed in a caddy on a clean personal care cart which was placed in the spa room. A couple of residents were noted to be wandering in the hallway near this area.

The resident's clinical records indicated that they had the above-mentioned treatment creams prescribed by the physician.

The PSW acknowledged that the creams were not supposed to be placed on the clean personal care cart and they were required to be placed in a designated treatment room that was secured and locked.

There was moderate risk to the safety of the residents with cognitive impairments when such drugs were accessible to everyone and not placed in a locked area.

Sources: Observations, interview with the PSW, the resident's clinical records.
[751]

WRITTEN NOTIFICATION: Administrator

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 249 (1) 3.

The licensee failed to ensure that the home had an Administrator who worked regularly on site at the home for at least 35 hours per week.

Rationale and Summary

Upon entering the home on February 13, 2023, Inspectors #751 and # 741753 were informed by the Assistant Director of Care that the home did not have an Administrator.

Review of the home's internal telephone directory indicated that the position was blank with no name.

The DOC confirmed that the Administrator position had been vacant for about two weeks and there was no designated staff covering for the role at the time. The DOC also stated that they have been in daily contact with the home's regional Vice President (VP) and would discuss any concerns related to the operation of the home with them if required.

On February 21, 2023, the Inspectors were informed that the home hired a new Administrator and that they would be present in the home within two weeks.

There was moderate risk to the residents and the operation of the home when the home's Administrator role was being vacant and not covered by any acting personnel for approximately four weeks.

Sources: Observations, the home's internal telephone directory, interviews with the DOC and ADOC. [751]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

1. Educates home's PSW staff, and agency PSWs (if any) on definitions of abuse and neglect, and the legislative requirements pertaining to prevention of abuse and neglect of residents.

a) The education will be conducted by a member of the management or clinical leadership team.
b) Keep a documented record of the education provided, who received the education, date of when the education was provided and the contents of the education and training materials.

2. Implement an auditing process related to Point of Care (POC) documentation by night shift PSWs related to residents' Continence Care and Toileting.

a) The audits will be conducted daily for four weeks.
b) The audits will be conducted by a member of the management or clinical leadership team.
c) Keep a documented record of the audits completed, dates of when the audits were completed, and any action taken when non-compliance is identified.
d) Analyze the results of the audits, correct any concerns identified and document the corrective actions taken.

Grounds

1. The licensee failed to ensure that the resident was protected from physical abuse by two PSW staff.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain. Physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

Rationale and Summary

A CIR was submitted to the MLTC regarding staff to resident physical abuse. The resident's written plan of care indicated that they had a medical condition, responsive behaviours, history of refusing personal care and required gentle approach when resisting care.

Review of the home's investigation notes and Close-Circuit television (CCTV) recording, indicated the resident became upset and was resistive when they were approached by the PSW's for care. The PSW's did not apply a gentle approach when the resident was resisting personal care.

The registered staff stated that they immediately responded to the situation and the PSW's stepped away from the resident. The resident then returned to their room and shut the door. The registered staff reported the incident immediately to the DOC.

The DOC acknowledged that the acts of PSWs were considered physical abuse, as they used physical force not appropriate to the provision of care for the resident.

There was high risk to the safety and well-being of the resident as the action of the two PSWs caused psychological distress to the resident.

Sources: CIR, the home's CCTV recording, interviews with staff, and the DOC.
[751]

2.The licensee failed to ensure that multiple residents were protected from neglect by an agency PSW.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary

A CIR was submitted to the Director, regarding multiple residents' neglect during a night shift, from 2300 hours to 0700 hours, as personal care was not provided to them by staff.

Review of the residents' clinical records indicated they had physical and cognitive impairments and required staff's assistance for personal care. Further review of the resident's clinical records indicated there was no Point Click Care (POC) documentation related to their personal care.

PSWs #135, #136, and #138 stated that when they started their shift that morning many of the residents in RHA were not provided personal care during the night. The PSWs also noted that the some of the residents had some redness on their skin upon discovering the incident however the redness was resolved by the end of their shift. PSW #138 stated that at the beginning of their shift they noted the agency PSW was resting on a couch RHA. The PSW further stated that they found the residents in their assignment had not received personal care during the night. Agency PSW #140 who came to help them at the time, informed them that they did not provide care to the residents because the residents required two persons assist and that nobody came to help them.

The registered staff confirmed they worked on the night of November 12, 2022, and conducted safety checks on all the residents in the RHA. The registered staff further stated in the morning, at approximately 0400 hours or 0430 hours, the agency PSW told them that they did not provide care to the residents as they were alone and could not provide care to the residents by themselves. The registered staff further stated that the agency PSW did not ask for help prior to that time. When they became aware of this issue, they could not help the agency PSW with any resident's care as they had other duties in a different RHA. The registered staff confirmed the agency PSW neglected the residents when they did not provide personal care to them for the entire shift.

The DOC confirmed this incident as neglect and stated the review of the home's CCTV recording showed that agency PSW was not observed going into the residents' rooms.

Failure to provide the residents' personal care by the agency PSW, violated their dignity and caused high risk of harm to their safety and well-being as they were found with skin irritation when their clothes and bed linens were soaked with urine and feces for several hours.

Sources: CIR, resident's clinical records, and interviews with staff.
[751]

This order must be complied with by May 31, 2023

COMPLIANCE ORDER CO #002 Policy to promote zero tolerance

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)

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

1. Educate RPN #103, RN #139, RN #141, RPN #137, PSW #145, dietary aide #143, and the home's the homes manager #121, on definitions of abuse and neglect, and the legislative requirements pertaining to prevention of abuse and neglect of residents, including but not limited to procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

a) Keep a documented record of the education provided, who received the education, date of when the education was completed and the contents of the education and training materials.

Grounds
1. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with when witnessed physical abuse of the resident was not reported properly to the home's DOC by the registered staff.

Rationale and Summary

A CIR was submitted to the MLTC, indicating a witnessed abuse of a resident by two PSW's. According to the CIR, staff observed two PSWs using force to provide care to a resident and the resident was resistive to care.

According to the attachment titled "The Definitions of Abuse & Neglect" in the home's prevention of abuse and neglect of a resident policy, an example of physical abuse was noted as "Rough handling; force that is excessive, causing bodily harm, pain, impairment, or psychological distress, and not appropriate to the provision of care".

The DOC and ADOC confirmed that the incident was reported to them by the registered staff immediately however the way they described it was more in a context of a responsive behaviour not being managed properly. The registered staff acknowledged that they did not consider the above-mentioned incident as a staff to resident abuse. Once Inspector #751 described the home's definition of abuse to them, they agreed and stated that the two PSWs did use force when the resident was resistive to staff providing care to the resident.

The ADOC further indicated when they saw the CCTV recording related to this incident, they immediately submitted the CIR.

Failure to report this witnessed staff to resident physical abuse in an appropriate way to the home's DOC, resulted in delaying the home's immediate investigation, reporting, and taking appropriate action in order to keep the resident safe from abuse by the two PSWs.

Sources: CIR, the home's CCTV recording, the home's policy titled "Prevention of Abuse & Neglect of a Resident, interviews with registered staff, DOC, ADOC, and other staff.

[751]

2. The licensee failed to ensure manager #121 complied with the home's abuse policy.

Rationale and Summary

A CIR was submitted to the Director related to an allegation of financial abuse of a resident. Manager #121 reported they were the manager, when the resident reported an allegation of financial abuse by a family member.

The home's policy titled “Prevention of Abuse & Neglect of a resident” indicated the following steps were to be taken when completing an investigation: The resident is interviewed, and detailed notes of the conversation are kept.; Anyone involved in the incident write, sign, and date a statement accurately. The investigative report is kept in a separate binder from the residents' clinical records. The community is required by law to report the results of the investigation via the applicable provincial reporting requirements and notify the resident the results of the investigation.

The DOC confirmed the home’s policy on Prevention of Abuse and Neglect was not followed. The DOC reported they had no investigation notes in the investigation binder despite asking manager #121 numerous times for the notes. The DOC did not know if the resident allegation of financial abuse was founded.

Manager #121 reported they did not have investigation or interview notes but had electronic mail (Email) correspondence with police. One Email documented an interview by the police with manager #121, two other emails sent by the police, requested the manager to provide them a list of stolen items and to contact the police if they did not hear back from them the following week. Manager #121 reported they did not fill out a list of the resident's stolen items and had tried following up with police via email, but the police did not email back. Manager #121 had no documented record of their attempts.

Manager #121 confirmed they did not know if the allegation of financial abuse towards the resident was founded or not. During the inspection the manager reported to inspector #741753 they had sent the lead detective an email to follow up on resident’s allegations of financial abuse. The detective sent an email back to the manager reporting the resident did not want the detective to investigate the claims of financial abuse and the investigation was closed.

The resident was at risk for further financial abuse when manager #121 did not follow the home's abuse policy in conducting appropriate investigation.

Sources: The home’s policy titled “Prevention of Abuse & Neglect of a Resident, correspondence with the police, and interviews with the DOC and manager #121.
[741753]

3. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was compiled when a report of multiple residents' neglect was not investigated and followed-up properly by staff.

Rationale and Summary

A CIR was submitted to the Director regarding multiple residents' neglect on the night, as personal care was not provided to them by staff. Review of the CIR further indicated that all the residents involved in this incident were going to have head to toe assessment completed which would be documented in Point Click Care (PCC).

The home's policy titled "Prevention of Abuse & Neglect of a Resident, VII-G-10.00", directed the nurses to document the current resident status on the resident's health record. Further the policy requires the Executive Director or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.

The residents' clinical records did not indicate any relative, or family communication regarding the neglect of the resident's care. The home's investigation notes did not include written and signed statements from all the staff involved in this incident or the home's interviews with the staff who initially became aware of this incident.

The DOC expressed that they did not conduct a proper investigation into this incident as per the home's abuse policy.

There was risk to the safety and well-being of the residents when the home did not conduct an appropriate investigation into this neglect incident.

Sources: CIR, multiple resident clinical records of residents, the home's policy titled "Prevention of Abuse & Neglect, and interviews with staff.
[751]

This order must be complied with by May 31, 2023

COMPLIANCE ORDER CO #003 Reporting certain matters to Director

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

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

1. Educate PSW #145 on the legislative requirements pertaining to prevention of abuse and neglect of residents.

   a) Keep a documented record of the education provided, date of when the education was completed and the contents of the education and training materials.

2. Develop and implement an auditing process to ensure incidents of suspected alleged abuse or neglect are reported immediately.

   a) The audits will be conducted daily for four weeks.
   b) The audits will be conducted by a member of the management or clinical leadership team.
   c) Keep a documented record of the audits completed, dates of when the audits were completed, and any action taken when non-compliance is identified.
   d) Analyze the results of the audits, correct any concerns identified and document the corrective actions taken.

Grounds

1.The licensee failed to ensure that witnessed physical abuse a resident by a PSW was reported immediately to the Director.

Rationale and Summary

The home submitted a CIR indicating, the PSW witnessed another PSW using force during the resident's care.

The PSW acknowledged they reported this incident to a registered staff two days after it had occurred. The DOC confirmed the above-mentioned incident was supposed to be reported immediately to the Director.

There was a risk to the resident when this allegation of staff to resident physical abuse was not reported immediately to the Director as it would delay the home's investigation process and pose further possible harm to the resident.

Sources: CIR, interviews with staff.
[751]

2.The licensee failed to immediately report to the Director when resident #027 was physically aggressive towards a co-resident.

Rationale and Summary

2. A CIR was submitted to the Director related to a resident to resident physical aggression three days after the occurrence.

The ADOC confirmed the resident's responsive behaviors towards their co-resident and agreed the action line was not called, and the CIR was submitted late.

There was risk to the safety and well-being of the resident when the home did not report this incident immediately as it delayed the home's investigation initiation and further follow-up action in a timely manner.

Sources: CIR, interview with ADOC.
[741753]

3.The licensee failed to ensure that a person who had reasonable grounds to suspect neglect of multiple residents occurred, immediately reported the suspicion and the information to the Director.

Rationale and Summary

A CIR was submitted to the Director, regarding multiple residents' neglect as personal care was not provided to them by staff.

The CIR indicated the incident occurred during the night shift. The registered staff working the morning shift reported the incident to the on-call manager on the same day. The CIR did not indicate the name of the registered staff who reported this incident to the on-call manager.

An Email communication by the dietary aid was also attached to the CIR which was sent to the home's DOC and previous Administrator. The Email communication indicated that the dietary aid was aware of this incident a day prior to sending the Email.

The dietary aide was not available during this inspection.

The on-call manager indicated that they were present in the home the day the incident occurred, however no one informed them about this incident.

The registered staff who worked during the night shift, confirmed the agency PSW informed them that they did not provide care to the residents during the night. The registered staff stated they did not report this incident to the on-call manager when resident care was not provided.

The DOC stated that anyone in the home who became aware of such incident were required to immediately report this to the Director. They further stated that they became aware of the above-mentioned Email by dietary aide, as well as receiving various reports by multiple staff regarding the care not provided to the residents in this specific home area during the night shift.

Failure to report an incident of resident's not receiving care immediately, put residents at risk of harm as it also delayed the home's investigation process and follow-up.

Sources: CIR, the home's investigation notes, Interviews with staff.
[751]

This order must be complied with by May 31, 2023

COMPLIANCE ORDER CO #004 Chief Medical Officer of Health (CMOH) and (Medical Officer of Health) MOH

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 272

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

1. The IPAC lead or designate will provide education to the six staff and one student, regarding current masking requirements as outlined in the current "COVID-19 guidance document for long-term care homes in Ontario." The IPAC lead will keep a documented record of who provided the education provided, who the education was provided to and the contents of the education.

2. The ADOC's who are responsible for their home area will conduct four daily masking audits each day for a period of four weeks. The masking audits will include staff and visitors' names, the date the audit was completed and what education was provided when staff/ visitors were observed not wearing their masks appropriately. When the home's ADOC's are unavailable, the home's management team or Charge Nurse will complete the daily audits.

3. The IPAC lead will analyze the results of the audits and will develop a method to communicate the results to the management team and all staff working in the home. The communication to staff and management will include the percentage of staff wearing their masks correctly and education regarding the importance of wearing masks correctly in home areas. The IPAC lead will provide the communication method used, results of the monthly masking audit and education provided to staff upon request of the inspector.

Grounds

The licensee has failed to ensure that the Minister's Directive 1.2: Covid-19 response measures for long-term care homes issued by the Chief Medical Officer of Health was followed in the home.

In accordance with the Chief Medical Officer of Health, the Covid- 19 response measures for long-term care homes, effective August 30, 2022; Minister directive 1.2, the licensee was required to ensure that the masking requirements as set out in this guidance document are followed.

Rationale and Summary

During the inspection, the inspectors observed numerous staff on different dates wearing their medical masks below their nose. The IPAC lead was aware of those staff not wearing their medical masks appropriately and provided education.

The IPAC lead agreed staff in the home were not wearing their medical masks correctly. The IPAC lead agreed that staff were to always wear their medical masks.

Failing to ensure staff wear medical masks in home areas put the residents at risk for infection.

Sources: COVID-19 Directive #3 for Long-Term Care Homes under Fixing Long-Term Care Act, 2021 observations, interviews with the IPAC lead, and staff.
[741753]

This order must be complied with by May 31, 2023

COMPLIANCE ORDER CO #005 Infection Prevention and Control Program

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

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

1. The IPAC lead or designate will provide education to PSWS #127, #116, #117, and RPN #104, regarding hand hygiene including the four moments of hand hygiene. The IPAC lead or designate is to provide education to PSW #100 regarding when to provide hand hygiene to residents. Keep a documented record of who provided the education, the date of the education provided, the names of the staff who were provide education and the contents of the education.

2. The registered staff or designate working the day and evening shifts will each conduct two PSW hand hygiene audits on their units. The hand hygiene audits must include the PSWs' names, the date of the audit and education provided to those staff not completing hand hygiene correctly. The night nurse or designate will conduct one PSW hand hygiene audit on each unit, and document the PSW's name, the date the audit was completed, and education provided to those staff not completing hand hygiene correctly. Hand hygiene audits will be completed by the registered staff for four weeks.

3. The IPAC lead or designate will complete one hand hygiene audit during snack pass and one hand hygiene audit during meal pass each day for four weeks. The IPAC lead or designate will rotate the audit dates to include auditing in all four resident home areas. On the weekend the audits will be completed by management working in the home. Keep a documented record of the date the audit was completed, and the names of those staff audited and were provided education.

4. The IPAC lead or designate will conduct two daily hand hygiene audits each day for four weeks, to ensure registered staff are completing hand hygiene. The audit will include who completed the audit, the date the audit was completed, the names of those staff audited and what education was provided when hand hygiene was not completed correctly. The daily audits will be completed on different home areas to ensure weekly audits include all four home areas. On the weekend the audits will be completed by the management team or charge nurse working in the home.

5. The IPAC lead will analyze the results of the hand hygiene audits and develop a way to communicate to staff the gaps identified on the audit. The communication to staff will include education on the four moments of hand hygiene and education that the IPAC lead has identified as gaps from the audits. Upon the request of the inspector, the IPAC lead will provide the communication method used to communicate the results of the audits, what education was provided as a result of the gaps identified from the audit and education on the four moments of hand hygiene.

6. The IPAC lead will have provide a copy of the additional precaution signs being used in the home for residents that are probable, suspected or confirmed cases of COVID-19, upon request of the inspector.

7. The IPAC lead or designate will conduct daily IPAC audits for two weeks, in area in COVID-19 outbreak to ensure staff are posting the correct additional precaution signs. Provide on the spot reinstruction to those staff not complying with the correct isolation signage procedures. Keep a documented record of the audits completed and the names of those staff who were provided on the spot training, upon request of the inspector.

8. The IPAC lead or designate will provide education to PSW #100 on completing donning and doffing of Personal Protective Equipment (PPE) for COVID-19 additional precautions. Keep a documented record of the date and what education was provided to PSW #100.

Grounds:

1. The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, the licensee did not ensure support for residents to perform hand hygiene prior to receiving meals and snacks according to additional requirement under the IPAC standard section 10.4 (h).

Rationale and Summary

A PSW was observed providing morning snacks to residents in an RHA. They did not assist residents to perform hand hygiene prior to the residents receiving their snacks.

In an interview, the PSW reported they did not assist residents with hand hygiene prior to their snacks as the residents had hand hygiene after breakfast.

The IPAC lead agreed staff were to assist residents with hand hygiene prior to snack pass and would provide staff education.

The home's policy, Hand Hygiene, indicated personal support workers/ health care aide and recreation/ program team will wash resident's hands before and after eating. The preferred method if hands are not visibly soiled is with alcohol-based hand rub (ABHR).

Failing to provide hand hygiene prior to snack pass increases the risk for the spread of infectious disease.

Sources: The home's policy titled "Hand Hygiene, IX-G 10, observation, interviews with staff and the IPAC lead.
[741753]

2. The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, the licensee did not comply with hand hygiene requirements, including, but not limited to, at the four moments of Hand hygiene (before initial resident/ resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident-to-resident environment as by

routine practices under section 9.1 (b).

A PSW was providing resident care in the spa room. Upon exiting the spa room, no hand hygiene was observed. The PSW then proceeded to the resident common area where they touched the television remote and began picking up empty dishes from resident's morning snack pass.

The PSW agreed that hand hygiene should have been completed when they left the spa room.

The PSW was observed bringing toiletries out of a resident's room and placed them on a clean linen cart. They did not conduct hand hygiene prior to re-entering the resident's room.

RPN #104 and PSW #116 reported they did not know the four moments of hand hygiene.

The home's policy on hand hygiene indicates the four moments of hand hygiene, as per the additional requirements in the IPAC standard.

The IPAC lead was made aware RPN #104 and PSW #116 did not know the four moments of hand hygiene and the staff were observed not completing hand hygiene after exiting a resident's environment. The IPAC lead reported the staff have been provided education on the four moments of hand hygiene numerous times.

Staff failing to complete hand hygiene and not knowing the four moments of hand hygiene increases the risk for the spread of infection in the home.

Sources: The home's policy titled "Hand Hygiene IX-G-10.10", interviews with staff and the IPAC lead. [741753]

3. The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with, related to additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal and disposal required under section 9.1 (f) of the IPAC Standard.

Inspector #741753, observed an additional precaution sign posted on a resident's door. The sign indicated PPE the required for entering the resident's room. Prior to the PSW entering resident 's room, did not don all the necessary PPE.

A PSW reported they did not follow the Personal Protective Equipment (PPE) requirements as posted on the resident's door as the resident no longer had symptoms and the sign posted for additional precautions was incorrect.

The registered staff reported the resident was on additional precautions for suspected case of an infection. The RPN reported the staff were to wear the required PPE when entering the resident's room.

The IPAC lead indicated the resident was on additional precautions and was a suspected case for infection. The IPAC lead reported the PSW was correct in their PPE selection. A few days later, the IPAC lead reported they had made a mistake and after reviewing the Public Health and Ministry of Long-Term Care guidance documents electronic communication, the appropriate PPE and selection was not followed by the PSW.

As a result of staff not donning appropriate PPE for residents with confirmed, suspected and probable cases of infection, increases the risk for the spread of infection in the home.

Sources: York Region, Community and Health Services Public Health letter dated January 3, 2023, the COVID-19 Guidance document: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units, Version 9 updated January 18, 2023, observation, and interviews with staff.
[741753]

4. The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with. Specifically, the licensee did not ensure that point-of-care signage indicated enhanced IPAC control measures were in place as required by section 9.1 (e) under IPAC standard.

The signage on the resident's door indicated additional precautions. Prior to entering the resident's room, staff and visitors were required to wear the appropriate PPE, however, the sign did not indicate to wear a specific type of PPE.

The IPAC lead reported the sign on a resident's door was correct, and the specific type of PPE was not required for residents with a suspected case of infection. They further indicated that the sign on the resident's door would indicate for staff and visitors to wear a specific type of PPE only when the resident was a confirmed case of infection. A few days later, the IPAC lead reported they had made a mistake and upon reviewing the Public Health and Ministry of Long-Term Care guidance documents electronic communication, the sign should have indicated that staff and visitors were required to wear a specific type of PPE for confirmed or suspected cases of infection.

The DOC confirmed staff interacting with a resident suspected or confirmed resident case of infection the appropriate PPE should be worn.

Failing to ensure correct signage is posted for additional precaution signage increases the risk for the spread of infection in the home.

Sources: York Region, Community and Health Services Public Health letter dated January 3, 2023, the COVID-19 Guidance document: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units, Version 9 updated January 18, 2023, observation, interviews with the DOC and IPAC lead.
[741753]

This order must be complied with by July 16, 2023

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

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

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

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

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

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

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

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