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 |
|---|---|---|---|
| Nov 2, 2021 | 2021_882760_0040 | 009584-21 | Critical Incident System |

### Licensee/Titulaire de permis

DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
161 Bay Street, Suite 2100 TD Canada Trust Tower Toronto ON M5J 2S1

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

Bon Air Long Term Care Residence
131 Laidlaw Street South Cannington ON L0E 1E0

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

JACK SHI (760)

## 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): October 28, 29, 2021.**

**The following intakes were completed in this critical incident inspection:**

**A log was related to an allegation of staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Infection Prevention and Control (IPAC) Manager, Registered Nurses (RN), Personal Support Workers (PSW) and the Director of Care (DOC).**

**During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.**

**The following Inspection Protocols were used during this inspection:**
**Dignity, Choice and Privacy**
**Infection Prevention and Control**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**
- **5 WN(s)**
- **4 VPC(s)**
- **0 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 environment related to infection prevention and control measures specified in Directive #3, regarding active screening of all staff, visitors, and anyone else entering the home for COVID-19 and universal masking requirements.

As per Directive #3, all staff and visitors are to be actively screened before they enter a long-term care home and staff are to adhere to universal masking policies in the home.

When the inspector arrived in the home, they were not actively screened by the staff prior to entry. The inspector was prompted to enter the home's basement, where the DOC was informed of this and directed the inspector to be screened in after the fact.

Furthermore, the inspector observed the screener asking two staff members their names and for one of them, their symptoms, but did not proceed to ask any additional questions related to their screening into the home.

The RN stated that they would often perform self-screening when they come into the home in the morning because there is no screener present during the time that they start their shift in the morning.

The IPAC Manager stated that during the periods where a screener is not present in the home, staff are to ring the doorbell and wait for a registered staff currently on duty to screen them in. The IPAC Manager confirmed that it was not appropriate for staff to self-screen themselves into the home.

In another observation, an RN was observed with wearing their mask below their nose while they were in a resident home area. The DOC stated this was not an appropriate practice related to the home's universal masking policies and all staff should have their surgical mask worn, covering their nose.

The observations demonstrated that there were inconsistent practices in the home related to the measures specified in Directive #3, putting residents at risk for contracting infectious diseases.

Sources: Directive #3; Observations made during the inspection; Interviews with the IPAC Manager, the DOC and other staff. [s. 5.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.***

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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 failed to ensure that a PSW followed a resident's plan of care related to their responsive behaviours.

During an investigation from the home with the PSW, they mentioned that the resident would often demonstrate responsive behaviours during a type of care they would receive. In the resident's care plan, it had indicated specific interventions to manage the resident's responsive behaviours, if they had demonstrated responsive behaviours during their care. The administrator and DOC confirmed that the PSW failed to follow the resident's care plan when the resident demonstrated responsive behaviours during their care.

Sources: Home's investigation report; the resident's care plan; Interviews with the DOC, the administrator and other staff. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #3: 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. The licensee failed to ensure that a staff member immediately reported an allegation of resident abuse to the Director.

According to the home's investigation, a staff member had suspected an allegation of resident abuse from a PSW. The staff member did not immediately report the allegation. The administrator stated that as per the home's policies and directions, staff are to report any allegation of resident abuse immediately. Failure to immediately report the allegation of resident abuse may result in the continuation of resident abuse between this PSW and resident.

Sources: Home's investigation; Interviews with the DOC and the 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 any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident., to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a PSW used safe transferring techniques with a resident, during their care.

During an investigation between the home and the PSW, the PSW mentioned they had performed a transfer with the resident. The PSW mentioned they experienced difficulty with the resident during this transfer. In the resident's care plan, an intervention was specified regarding how to transfer the resident, if staff had experienced difficulty with them. The DOC confirmed that the PSW did not follow these interventions and the transfer the PSW performed was not safe. Failure to follow the resident's proper transfer status may result in an injury to the resident.

Sources: Home's investigation report; a resident's care plan; Interviews with the DOC and other staff. [s. 36.]

***Additional Required Actions:***

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

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

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

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a resident was treated with dignity and respect during their care.

A review of the home's investigation notes indicated that a PSW performed an action to the resident during their care. The administrator and DOC confirmed that the resident was not treated with dignity and respect based on the actions performed by this PSW to the resident.

Sources: Home's investigation report; Interviews with the administrator, the DOC and other staff. [s. 3. (1) 1.]

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**Issued on this 3rd day of November, 2021**

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

**Original report signed by the inspector.**