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

Sudbury Service Area Office
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Original Public Report

Report Issue Date May 24, 2022
Inspection Number 2022_1195_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Schlegel Villages Inc.

Long-Term Care Home and City
Coleman Care Center, Barrie Ontario

Lead Inspector
Amanda Belanger (736)

Inspector Digital Signature
Amanda Belanger
Digitally signed by Amanda Belanger
DN: cn=Amanda Belanger, o, ou, email=amanda.belanger@ontario.ca, c=CA
Date: 2022.06.20 15:03:48 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 25-29, 2022. Off site activities occurred on May 3, 2022.

The following intake(s) were inspected:
- Two logs related to resident falls with injury;
- Two logs related to allegations of staff to resident abuse;
- Two logs related to a complaint and allegation of improper care of a resident; and
- One log related to a complaint of a violation of resident rights.

The following **Inspection Protocols** were used during this inspection:
• Councils
• Infection Prevention and Control (IPAC)
• Medication Management
• Pain Management
• Prevention of Abuse and Neglect
• Reporting and Complaints
• Residents' Rights and Choices
• Skin and Wound Prevention and Management
• Whistle-blowing Protection and Retaliation
• Falls Prevention

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

WRITTEN NOTIFICATION SKIN AND WOUND ASSESSMENTS

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 50. (2) b (iv).
The licensee has failed to ensure that when the resident had impaired skin integrity, the areas were assessed at least weekly, by a member of the registered staff.

Rationale and Summary
Four areas of impaired skin integrity were noted on the resident. The areas of impaired skin integrity were not assessed weekly, with assessments being completed between eight and 17 days late.

Sources: The resident's skin assessments and progress notes; licensee policy titled "Skin and Wound"; and interviews with Associate Director of Nursing Care (ADNC) and other relevant staff. [736]

WRITTEN NOTIFICATION POLICE NOTIFIATION OF ABUSE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 98.
The licensee has failed to ensure that the appropriate police force was immediately notified of the allegation of abuse of two residents by staff.

Rationale and Summary
An allegation of staff to resident abuse was brought forward that involved two residents. The allegation of abuse towards one of the residents was determined to be founded. The General Manager (GM) confirmed police were not immediately notified of the allegation of staff to resident abuse.

Sources: Critical Incident (CI); internal investigation notes; licensee policy titled "Investigation Process for Suspected Abuse of a Resident by a Team Member, Volunteer or Visitor" and an interview with GM. [736]

WRITTEN NOTIFICATION STAFF INVOLVED NAME IN CIS REPORT

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 104 (1) 2. ii.
The licensee has failed to ensure that the name of the staff member involved in an allegation of abuse towards a resident was included in the report to the Director.

Rationale and Summary
The home submitted a report to the Director that alleged staff to resident abuse. The report did not include the name of the staff member involved.

The GM confirmed that the name of the staff member involved in the allegation of abuse should have been in the report, and was not.

Sources: CI report; internal investigation notes; and an interview with GM.
[736]

WRITTEN NOTIFICATION SDM NOTIFICATION OF ALLEGATION OF ABUSE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s.97 (1)(b)
The licensee has failed to ensure that when there was an allegation of staff to resident abuse, the residents substitute decision makers (SDMs) were notified of the allegation.

Rationale and Summary
a) There was an allegation made that a staff member had verbally abused one resident and physically abused another resident. The residents' SDMs were not made aware of the allegation of abuse.

b) During an internal investigation into the allegation of abuse, there was an additional allegation of staff to resident emotional abuse. The internal investigation, nor the progress notes indicated that the resident's SDM was notified of the allegation.

The GM indicated that in all allegations, the SDMs should have been notified of the staff resident abuse and were not.

Sources: Internal investigation notes related to CI report; the residents' progress notes; licensee policy titled "Investigation Process for Suspected Abuse of a Resident by a Team Member, Volunteer or Visitor"; and an interview with GM. [736]

WRITTEN NOTIFICATION IMMEDIATE REPORTING

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s.24. (1) 2.
1) The licensee has failed to ensure that an allegation of staff to resident neglect, involving the resident, was immediately reported to the Director.

Rationale and Summary
There was a concern brought forward to the Neighbourhood Coordinator, that the resident had been neglected during a shift, and that care was not provided as per the resident's plan of care.

The GM confirmed that it was an allegation of neglect, which should have been immediately reported to the Director, and had not been reported.

Sources: Internal Complaints Records; licensee policy titled "Mandatory Reporting; and interview with GM. [736]

2) The licensee has failed to ensure that allegations of staff to resident abuse were immediately reported to the Director.

Rationale and Summary
a) The Personal Support Worker (PSW) was observed speaking to the resident in a way that threatened the resident and indicated that the staff were going to provide care outside of the resident's plan of care. The PSW was also heard telling the resident that there may be negative consequences to their actions, and that assistance would not be provided by the staff. The interaction between the PSW and resident was not reported to the management team until a day later; at which time the allegation of abuse was reported to the Director.

The GM indicated that allegations of abuse that were witnessed or suspected by staff were to be immediately reported to their supervisor, so that it can be reported to the Director. The GM confirmed that the allegation of staff to resident abuse that took place, was not immediately reported to the Director and should have been.

b) A communication was directed to the Director of Nursing and Care (DNC), alleging physical, verbal and emotional abuse of three residents, after business hours. The communication was not received by the DNC until the next day, at which time the allegations were reported to the Director, over 24 hours after the incident was alleged to have taken place. The GM confirmed that the allegation was not immediately reported to the Director, and should have been.

Sources: CI report; internal investigation notes; licensee policy titled "Mandatory Reporting"; and an interview with the GM. [736]

c) The licensee has failed to ensure that an allegation of staff to resident abuse was reported to the Director.

Rationale and Summary
During an internal investigation into the allegation of staff to resident abuse, it was noted that the staff also indicated that another resident may have been emotionally abused by the staff member. The GM confirmed that no CI was reported to the Director related to the allegation of staff to resident emotional abuse. [736]

Sources: CI report internal investigation notes; licensee policy titled “Mandatory Reporting”; and, interview with the GM.

WRITTEN NOTIFICATION ABUSE POLICY COMPLIED

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s.20
The licensee has failed to ensure that the licensee’s abuse policy was complied with.

Specifically, the licensee failed to ensure that when there was an allegation of abuse, there was a detailed description placed in the resident’s records.

Rationale and Summary
The licensee policy titled “Investigation Process for Suspected Abuse of a Resident by a Team Member, Volunteer or Visitor” directed staff to put detailed documentation of the allegation into the resident’s chart when there was an allegation of resident abuse.

a) Staff brought forward an allegation of staff to resident verbal and emotional abuse of a resident. A review of the resident’s progress notes and assessments showed no description or details of the concerns that were brought forward.

Sources: CI report; the resident’s progress notes and assessments; licensee policy “Investigation Process for Suspected Abuse of a Resident by a Team Member, Volunteer or Visitor”; and an interview with GM. [736]

b) There was an allegation of staff to resident abuse, however, there was no documentation in the resident’s chart related to the allegation.

Sources: The resident’s progress notes and assessments; licensee policy titled “Investigation Process for Suspected Abuse of a Resident by a Team Member, Volunteer or Visitor”; CI reprot; internal investigation notes; and an interview with GM. [736]

c) There was an allegation of staff to resident verbal abuse involving a resident. There was no documentation in the resident’s chart related to the allegation of abuse.

Sources: Resident’s progress notes; CI report; internal investigation notes; licensee policy titled “Investigation Process for Suspected Abuse of a Resident by a Team Member, Volunteer or Visitor”; interview with GM. [736]

d) There was an allegation of staff to resident abuse involving a resident. The resident’s chart had no description of the allegation.

Sources: The resident’s progress notes; CI report; internal investigation notes; licensee policy titled “Investigation Process for Suspected Abuse of a Resident by Team Member, Volunteer or Visitor”; and interview with the GM. [736]

e) During an investigation into another allegation of resident abuse, it was noted that a staff member felt that another resident may have been emotionally abused by a staff member based on the behaviour and conduct of the staff, as well as the reaction of the resident. There was no documentation in the resident's chart to detail the incident or allegation.

Sources: The resident's progress notes; licensee policy titled "Investigation Process of Suspected Abuse of a Resident by Team Member, Volunteer or Visitor; and an interview with GM. [736]

COMPLIANCE ORDER [CO #001] RESIDENT RIGHTS

NC#07 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 3 (6)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (b) prepare, submit and implement a written plan for achieving compliance with a requirement under this Act. 2021

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 3(6).

The Licensee shall:
-Ensure that the resident's right to have visitors of their choosing is respected, and
-Ensure that the resident's designated essential caregiver(s) are permitted to provide supports to the resident in person.

Compliance Plan [*FLTCA, 2021, s. 155 (1) (b)*]

Specifically, the licensee shall prepare, submit and implement a plan to ensure that the resident's right to have visitors of their choosing is respected, and ensure that the resident's designed essential caregiver(s) are permitted to provide supports to the resident in person.

The plan must include but is not limited to:

- how the resident's rights to have visitors will be respected
- what the home will implement to ensure that the resident's essential caregiver(s) are permitted to provide supports to the resident in person

Please submit the written plan for achieving compliance for inspection 2022_1260_0001 to Amanda Belanger, LTC Homes Inspector, MLTC by May 30, 2022

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

Non-compliance with: FLTCA, 2021, s.3 (6).

The licensee has failed to ensure that the resident's right to receive visitors of their choosing was respected.

Rationale and Summary
Coleman Care Center restricted a resident's essential caregiver from visiting the home. The resident indicated that they wanted their essential caregiver to be able to visit in person.

The GM confirmed that the resident was not able to have their essential caregiver visit at the home for a specified period of time.

Sources: The resident's progress notes and care plan; internal communication notes; licensee's policy titled "Resident Rights"; interviews with the resident, GM and other relevant staff. [736]

This order must be complied with by June 3, 2022

COMPLIANCE ORDER [CO #002] INFECTION PREVENTION AND CONTROL

NC#08 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 102 (2) a and b

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 102 (2) a and b of Ontario Regulations 246/22.

Specially, the licensee shall ensure that the residents are provided hand hygiene prior to the start of their meals.

Grounds

Non-compliance with: O. Reg. 246/22 s.102. (2) a and b

The licensee has failed to ensure that hand hygiene was provided to the residents prior to their meal being provided.

Rationale and Summary
The Inspector observed a resident in the hallway prior to meal service, touching the handrails. The Inspector also observed another resident in their wheelchair, adjusting themselves in the chair, using the wheels. Staff members brought the residents their lunch meals, however, did not encourage either resident to perform hand hygiene prior to beginning their meals. The home was in a confirmed COVID-19 outbreak at the time of the observations.

The IPAC lead for the home confirmed that residents were to have hand hygiene offered prior to meals as part of the home's IPAC program.

Sources: Inspector observations; the residents' progress notes; licensee's hand hygiene policy; and interview with the PSW, the IPAC lead and other relevant staff. [736]

This order must be complied with by June 3, 2022

COMPLIANCE ORDER [CO #003] PLAN OFCARE

NC#09 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6 (7).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 6 (7) of the FLTCA, 2021.

Specially, the licensee shall ensure that the resident is provided the care as set out in their plan of care.

Grounds

Non-compliance with: FLTCA, 2021, s.6(7)

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

Rationale and Summary
The resident's plan of care directed staff to provide a specific intervention at set intervals for prevention of impaired skin integrity.

A complaint response form indicated that during an internal investigation, staff had indicated that they had not provided the specified intervention at the correct intervals for the resident during the shift.

During the inspection, the Inspector observed the resident and noted that the specified intervention was not provided at the set intervals by the staff, as specified in the resident's plan of care. At the time of the inspection, the resident had impaired skin integrity.

Sources: Inspector observations; internal complaint investigation form; the resident's plan of care; and interviews with PSW, and other relevant staff. [736]

This order must be complied with by June 3, 2022

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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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

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
email: 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.