Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 10, 2019	2019_530726_0006	013510-19, 013895-19	Complaint

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Craiglee Nursing Home
102 Craiglee Drive SCARBOROUGH ON M1N 2M7

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

REBECCA LEUNG (726), GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 15, 17, 19, 22-25, 29-31, August 1, 2, 6, and 7, 2019, and off-site on July 16, 18, August 8, 9, 13, 14, 15 and 20, 2019

The following Complaint intake was inspected during this inspection:
Log #013510-19 related to prevention of abuse

The following Critical Incident System intake was inspected during this Complaint inspection:
Log #013895-19 related to prevention of abuse

During the course of the inspection, the inspector(s) spoke with the Vice President of Licensee, Director of Operations, Regional Director, Administrator, Director of Care, Police Officers, Environmental Services Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, family members and substitute decision-makers (SDM).

During the course of the inspection, the inspectors reviewed videos (provided by the SDM) related to provision of care by the staff, residents' health records and observed staff to resident interactions, and reviewed home's annual program evaluation, policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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. 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 ensure that resident #001 was protected from abuse by anyone.

Under O. Reg. 79/10, s.2 (1), for the purpose of the definition, "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain.

Under O. Reg. 79/10, s.2 (2), for the purposes of the definition, 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.

The Ministry of Long-Term Care (MLTC) received a complaint from resident#001's SDM (#105) on an identified date regarding a staff to resident abuse. SDM #105 reported concerns about resident #001's safety related to provision of care by the home's staff.

Critical Incident System (CIS) report was submitted to the MLTC related to a staff to resident physical abuse incident involving resident #001. A review of the CIS report indicated that the police was involved, and a staff member was charged on an identified date based on the videos provided by SDM #105. The home's management staff was informed by the police officers that there might be other staff involved in the incident.

In an interview, the administrator (#101) stated that SDM #105 went to them on an identified date to report concerns with resident #001's safety. However, SDM #105 refused to provide the administrator with any name of staff or date and time of any related incident. Administrator #101 stated that they were unable to initiate the investigation at that time. Administrator #101 confirmed that based on the information provided by the police officer and SDM #105 related to resident #001, they had suspended a specified number of staff from duties during the investigation nine days after SDM #105 first reported the incident to the home. In an interview, DOC #102 stated that intensive monitoring was implemented for resident #001 to ensure their safety.

In an interview, SDM #105 and SDM #106 stated that they were concerned with the unexplained altered skin integrity on resident #001's identified body parts. They had reported their concerns to the home's management staff about a month ago and the staff informed them about the possible cause for the resident #001's altered skin integrity and implemented specified interventions accordingly. SDM #105 and #106 were frustrated as

the home did not take further action to address their concerns about resident #001's safety. SDM #105 informed the inspector that they had installed a surveillance camera inside resident #001's room and provided the inspector with a copy of a number of videos which were recorded within a specified date range. SDM #105 later agreed that the inspector could show the home's management team all the videos.

The inspectors then met with the administrator (#101) and Director of Care (DOC #102) on the identified dates to show them the videos provided by SDM #105. The administrator #101 and DOC #102 assisted the inspector to identify the staff shown in the videos as they were watching the videos. At the end of the meetings, a number of staff involved in the incident were identified. The administrator #101 and DOC #102 acknowledged the following initial findings:
- As shown in some videos, one staff had physically abused resident #001.
- A number of the videos showed that some staff had used excessive force when providing the identified care for resident #001. Multiple staff had provided the identified care for resident #001 in bed by themselves. The rough handling could increase the shearing force leading to potential altered skin integrity.
- As shown in some videos, multiple staff should have requested another staff to assist with providing the identified care for resident #001 in bed as resident #001 required two-person assistance for bed mobility and the identified care.

The inspectors reviewed all videos provided by SDM #105 and identified multiple incidents in which resident #001 was physically abused by the staff including excessive force being used during provision of care. In some videos, registered staff was present and witnessed the incident, but did not stop the abuse and did not take action to protect the resident. The above-mentioned findings were acknowledged by the DOC and the administrator during interviews and at the exit debriefing.

Inspector #726 then conducted a record review for the specified date range and observation for resident #001 to determine the injury and/or pain caused to the resident, and resident's functional status and care needs:

a. A review of an identified assessment completed on an identified date, indicated that resident #001 was identified with some functional issues and required specified assistance with two persons for their identified activities of daily living (ADLs).

b. A review of resident #001's care plan indicated that under a focus of impaired skin integrity, some of the interventions included specified assistance with two persons for

identified ADLs and the application of a specified protection device.

c. A review of a progress note for an identified date written by RPN #128, indicated that the assigned PSW reported a new altered skin integrity on an identified body part of resident #001. A review of resident #001's identified assessment for an identified date completed by RPN #128, indicated the resident did not complain of pain related to the identified altered skin integrity. A review of an incident report for an identified date completed by RPN #128, indicated the predisposing factors included resident's identified skin condition and the incident might have occurred when resident went on leave of absence (LOA) with family. In an interview, SDM #105 stated that they were frustrated when the staff informed them regarding the new altered skin integrity that was observed on resident #001 and that, the staff assumed the altered skin integrity was caused by the family and did not initiate an investigation to identify the cause of the unexplained altered skin integrity.

d. A review of resident #001's specified notes from assessment for an identified date written by RPN #128, indicated that an altered skin integrity was observed on an identified body part.

e. A review of resident #001's specified notes from assessment for an identified date written by RPN #128, indicated that altered skin integrity was observed in other identified body parts.

f. A review of resident #001's specified notes from assessment for an identified date written by RPN #127, indicated that new and old altered skin integrity of different types were observed in various body parts.

g. On an identified date, the inspector observed altered skin integrity on multiple identified body parts of resident #001, and some of them appeared to be resolving.

h. A review of the specified assessments completed within a specified date range, indicated resident #001's was in no pain most of the time, and in mild pain for a specified number of days.

i. A review of the medication administration record for an identified month, indicated resident #001 was on an identified medication with specified dosage and frequency for pain since an identified date. In an interview, RPN #128 stated that resident #001 was taking the identified medication for the pain related to the altered skin integrity in the

identified body parts.

In the interviews, PSW #121 and #125 stated that sometimes when they provided the identified care for resident #001 alone because other staff were not available to help them.

In the interviews with the staff involved - PSWs #117, #118, #119, #120, #121, #122, #123, #124, #125, and #126, and RPN #127 and #128, they confirmed their awareness of the home's policy on promoting zero tolerance of abuse and neglect and acknowledged the use of excessive force during provision of care would be considered a form of physical abuse.

A review of the nursing progress note indicated that resident #001 was discharged and transferred to another long-term care home on an identified date.

Please refer to the grounds provided for Compliance Order #003 issued pursuant to LTCHA, s. 75. (2).

Please refer to the grounds provided for Written Notification #5 issued pursuant to LTCHA, s. 6 (7).

During the review of the videos provided by SDM #105, the inspectors identified multiple incidents related to staff to resident physical abuse and use of excessive force during provision of care. It is noted that all the video recordings except two, did not have audio and therefore inspectors could not hear the residents' reaction. During the record review, the inspector identified documentation of specified altered skin integrity written by the registered staff. The inspector also observed identified altered skin integrity on the resident on the first day of inspection. The licensee has failed to ensure that resident #001 was protected from physical abuse by the staff. [s. 19. (1)]

Additional Required Actions:

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

WN #2: 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents #001, #002 and #003.

A complaint was submitted to the MLTC on an identified date, regarding family member's concerns after watching videos from a video camera that the family had been set up at resident #001's bedside. The family members who are Substitute Decision Makers (SDM) identified physical and verbal abuse by staff to resident #001 and they notified the home.

A review of resident #001's identified assessment for an identified date, indicated that resident #001 had some identified functional issues requiring specified assistance with two persons for their identified ADLs. Review of an identified assessment for an identified date, indicated that the therapist identified that the resident had specified functional issues and needed specified assistance with two persons for bed mobility, transfer and all basic ADLs. A review of resident #001's written plan of care revised last on an identified date, under focus section for bed mobility, transfer, and ADLs, identified that the resident needed specified assistance with two persons for personal care. The written plan of care also guided the staff to provide a specified care on a specified time interval for an identified altered skin integrity on the resident. The resident had a specified therapeutic device to promote the healing of an identified altered skin integrity.

A review of the videos for an identified date range indicated the following:
- On a number of occasions, only one staff provided care to resident #001, for identified ADLs and bed mobility instead as the plan of care indicated, two staff to provide care for the identified ADLs.
- The staff did not use safe positioning techniques when they repositioned resident #001 and when they turned the resident during provision of care.
- Two staff identified by DOC as PSW #122 and PSW #125 were observed transferring resident #001 using a specified transferring equipment with unsafe transferring technique.
- One PSW tried to apply a specified transferring device to resident #001 while the resident was sitting in a wheelchair. The PSW pulled the resident forward standing in front of the resident and tried to reach at the back of the resident to apply the specified transferring device as low behind the resident's back as possible.

- Transfer of resident #001 from bed to a wheelchair by two staff, one identified as PSW #122 who was trying to connect the specified transferring device to the specified transferring equipment while the equipment, with the resident in the specified transferring device was in motion.
- One staff identified by the DOC as PSW #120 and an unidentified staff repositioned the resident after the resident slid low in the bed. The staff grabbed the resident under their arms and slid them higher up in the bed with head of the bed still elevated, placing the resident at risk for impaired skin integrity.
- Used unsafe technique when one staff turned the resident from side to side, pulling off a therapeutic device that the resident had attached.
- Two staff identified by the DOC as PSW #122 and PSW #116 repositioned the resident in bed by grabbing the resident's upper extremities and pulling the resident up, while the head of the bed was still elevated to a resting position.
- Review of another number of videos showed unsafe repositioning and improper positioning technique of the resident provided by either one or two staff as identified by the DOC by names and their titles. The identified PSWs would grab resident's upper extremity and another part of the body, indicated to be the resident's lower extremity and would lift them and carry over the resident's body to the other side of the bed, then quickly pushing the resident's back to ensure that the resident stayed all the way on the other side. It was particularly challenging for one staff.

Interviews with all the staff identified on the videos, confirmed that resident #001 needed a specified assistance by two staff for identified ADLs and bed mobility. They also confirmed that the resident needed specified assistance with two staff for continence care. Further, the PSWs acknowledged that during provision of care to resident #001, because they did not always have a second person for assistance, they were not able to provide proper transfer and positioning.

In an interview with the DOC after reviewing the videos, the DOC confirmed that the staff identified in the videos did not use safe transferring and positioning devices or techniques when assisting resident #001.

2. An observation conducted in resident #002's room on an identified date, indicated that resident #002 had been transferred from bed to a wheelchair by PSW #110 using a specified transferring equipment. It was observed the PSW was removing the specified transferring equipment away from resident #002 who was sitting in a wheelchair in their room. The PSW indicated that RPN #112 came and assisted them to transfer the resident using the specified transferring equipment.

A review of resident #002's identified assessment for an identified date, and written plan of care indicated that the resident was at an identified cognitive functional status. The written plan of care also indicated that the resident had been complaining of identified symptoms in specified body parts. The plan of care guided the staff to use specified assistance by two staff for transfers with a specified transferring equipment.

Interview with RPN #112 stated that they did not assist PSW #110 during the transfer with the specified transferring equipment that morning.

In an interview resident #002 indicated that many times only one staff transferred them, and when they are short, they work faster than is safe and that it was worrying. Further, the resident stated that this morning, PSW #110 was alone when they transferred them from bed to a wheelchair using the specified transferring equipment.

An interview with the DOC indicated that staff is expected during every transfer with specified transferring equipment, to be completed by two staff. Further the DOC explained that PSW #110 should not transfer the resident alone using the specified transferring equipment, but to ask for assistance of a second staff. The PSW was re-educated on how to complete safe transferring when assisting residents.

3. An observation conducted on an identified date, in resident #003's room identified that resident #003 had been transferred with a specified transferring technique from wheelchair to a toilet by PSW #110 and RPN #112. The PSW indicated that the RPN assisted them to transfer the resident from wheelchair to the toilet, and the RPN confirmed that they transferred the resident with the specified transferring technique.

The written plan of care stated two staff to use a specified transferring equipment, to transfer the resident from wheelchair to a commode and vice versa using specified assistance.

An interview with PSW #110 indicated that the resident requested to go to the toilet and the specified transferring equipment was not available at that time, so they transferred the resident by two-person using the specified transferring technique. In an interview with the RPN, they stated that resident #003 needed specified assistance for transfer using a specified transferring equipment by two staff for safety, but at the time the specified transferring equipment was not available, so they transferred the resident using the specified transferring technique.

In an interview, the DOC stated that the staff had to provide safe transfer and in this case, they should use another specified transferring equipment if the specified transferring equipment was not available and that, specified transferring technique was not safe. [s. 36.]

Additional Required Actions:

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

WN #3: 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 screening measures including police record checks were conducted in accordance with the regulations before hiring staff.

A review of the personal folders of the involved PSWs, indicated that police record checks were not conducted for some of the PSWs before or after they were hired, and one PSW had police record check conducted after hiring.

In an interview, the DOC #102 acknowledged that the home should have conducted the police record checks for all PSWs prior to hiring. [s. 75. (2)]

Additional Required Actions:

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

WN #4: 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respected and promoted resident #001's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

A review of resident #001's identified assessment for an identified date, indicated that the resident needed specified assistance by two staff for identified ADLs, transfer and bed mobility.

A review of the videos for the specified date range, revealed on a number of occasions, it was noted that when the staff provided care to the resident, they exposed the resident's body and left it uncovered while adjusting the resident's bed to a convenient level, when waiting for an RPN to come in to provide the specified treatment, or to go and pick up supplies for providing care. The resident's body was uncovered while the PSWs were providing identified personal care on different areas of their body.

In interviews with the staff identified in the videos, all staff was aware that one way of respecting and promoting the resident's right to be treated with courtesy and respect their dignity was to provide privacy while providing personal care. They all agreed that leaving the resident's body exposed while providing personal care was considered as not respecting the resident's dignity.

An interview with RPN #127 identified in the videos and RPN #128 identified in the videos, after reviewing the videos acknowledged that they did not treat resident #001

with courtesy and respect and did not respect their dignity as they did not take any action when they saw the resident's exposed body.

Interview with the DOC after watching the videos confirmed the staff did not fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that they fully respected and promoted resident #001's right to be afforded privacy in treatment and in caring for his or her personal needs.

Review of the resident's plan of care indicated that the resident resided in a specified room with another resident. A review of a number of identified videos for the specified date range, revealed that on a number of occasions (shifts), it was noted that when the staff provided treatment and personal care to resident #001 the privacy curtains were not closed. In interviews with the staff identified on the videos, all staff were aware that one way of respecting and promoting the resident's right, and afford privacy in treatment and in caring for their personal needs was to apply the privacy curtain at the time when staff provided personal care and treatments to the resident.

An interview with RPN #127 identified in the videos and RPN #128 identified in the videos, after reviewing the videos acknowledged that they failed to respect and promote the resident's right to be provided privacy when provided treatment and care to resident #001.

In an interview with the DOC after reviewing the videos, the DOC confirmed that the staff failed to respect and promote resident #001's right to be provided privacy in treatment and in caring for his or her personal needs. [s. 3. (1) 8.]

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 following rights of residents are fully respected and promoted:
- 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, and
- every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #5: 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 resident #001 as specified in the plan.

A complaint was submitted to the MLTC regarding family member's concerns after watching videos from a video camera, they had set up at resident #001's bedside. The family members who are Substitute Decision Makers (SDM) identified physical and verbal abuse by staff to resident #001 and they notified the home.

A review of resident #001's health record indicated that on the identified assessment for an identified date, the resident was identified to need specified assistance by two staff for identified ADLs, bed mobility and transfer using a specified transferring equipment. Review of the therapist's identified assessment for an identified date, the therapist identified that the resident needed a specified level of assistance for bed mobility, transfer and all basic activities of daily livings (ADLs).

A review of resident #001's written plan of care revised last on an identified date, under the specified focus sections, identified that the resident needed specified assistance by two staff to provide care to resident #001.

Review of the PSWs' identified documentation records for the identified months, indicated that the resident had not been provided the identified ADLs by two staff as indicated in the plan of care during the identified shifts on a number of occasions.

A review of a number of videos revealed the resident was not provided the identified ADLs by two staff as indicated in the plan of care on a number of different occasions.

Interviews with all the staff identified on the videos, confirmed that resident #001 needed a specified level of assistance by two staff for the identified ADLs, and they needed specified assistance by two staff for identified continence care. However, all interviewed PSWs stated that when they did not have available staff to assist, they provide care alone.

In an interview with DOC after reviewing the videos, the DOC confirmed that the staff identified in the videos did not provide care to resident #001 as indicated in the plan of care. [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.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist resident #001 with eating, including safe positioning.

A review of resident #001's identified assessment for an identified date, indicated the resident was on a specified therapeutic diet and they were identified to need specified assistance by one staff for feeding.

A review of resident #001's written plan of care revised last on an identified date, under an identified focus section indicated the resident was identified with a specified functional issue. The goal set for this issue was to minimize the risk of an identified clinical condition through the next review period and the resident was to have a specified food texture.

A review of the videos identified the following:

- A staff member identified by the DOC as PSW #116, was feeding resident #001, while the resident was not properly positioned in bed, but rather resting with closed eyes. The head of the bed was elevated approximately 45 degrees. The resident would not open their mouth wide and the PSW would quickly drop the food in the resident's mouth causing food to spill around the resident's lips. The PSW scooped the excess food using the utensil and put the food in the resident's mouth. The PSW used the utensil to touch the resident and wake them up and continued with feeding.

- A staff member identified by the DOC as PSW #120, was giving to resident #001 a beverage. The resident was lying in bed with the head of the bed elevated about 30 to 40 degrees. After the resident had consumed part of the beverage, the PSW elevated the bed to about 45 degrees and continued giving the resident the drink while using their hand to prop up the resident.

- Further review of videos with PSW #120 showed another occasion when the PSW fed the resident with an identified feeding utensil overflowing with food that spilled around the resident's mouth. The PSW scooped the food with the spoon off the resident's chin. The resident was not positioned for feeding in bed as the head of the bed was elevated only about 45 degrees.

In an interview after watching the videos, the DOC stated that resident #001 was not properly positioned during feeding. The DOC stated the resident should be positioned around 90 degrees when they are set to be fed. [s. 73. (1) 10.]

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 has a dining and snack service that includes, at a minimum, the proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #7: 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. (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 all staff received retraining on Residents' Bill of Rights and home's policy to promote zero tolerance of abuse & neglect of residents annually.

Under O. Reg. 79/10, 219 (1), the intervals for the purposes of subsection 76 (4) of the Act are annual intervals.

A review of the home's training record for 2018, indicated that some of the staff did not complete the training on the Residents' Bill of Rights, and some of the staff did not complete the training on Zero Tolerance of Abuse and Neglect.

In an interview, the DOC #102 acknowledged that all staff should have attended the training on Residents' Bill of Rights and Zero Tolerance of Abuse and Neglect in 2018. [s. 76. (4)]

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 all staff receive retraining on Residents' Bill of Rights and home's policy to promote zero tolerance of abuse and neglect of residents annually, to be implemented voluntarily.

WN #8: 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 has failed to ensure that at least once every calendar year, an evaluation was 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 were required to prevent further occurrences.

In an interview, the DOC #102 confirmed that the home did not complete the annual evaluation for 2016 and 2018 to determine the effectiveness of the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 99. (b)]

2. The licensee has failed to ensure that the results of the analysis of every incident of abuse or neglect of a resident at the home were considered in the annual evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents.

A review of the home s Quality Program Evaluation Resident Abuse, indicated the home completed the annual evaluation for 2017 to determine the effectiveness of the home s policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

A review of the email message received from the DOC #102 on an identified date, indicated that some of the abuse incidents occurred in 2017 were considered in the home's Quality Program Annual evaluation.

In an interview, the DOC #102 acknowledged that the annual program evaluation completed in January 2018 did not include the analysis of every incident of abuse or neglect of a resident that occurred in 2017. The DOC #102 also confirmed that the home did not review the results of the analysis of every incident of resident abuse or neglect in 2016 and 2018. [s. 99. (c)]

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 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; and that the results of the analysis undertaken under clause (a) are considered in the evaluation, to be implemented voluntarily.

Issued on this 17th day of September, 2019

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	REBECCA LEUNG (726), GORDANA KRSTEVSKA (600)
Inspection No. / No de l’inspection :	2019_530726_0006
Log No. / No de registre :	013510-19, 013895-19
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 10, 2019
Licensee / Titulaire de permis :	CVH (No. 1) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Craiglee Nursing Home 102 Craiglee Drive, SCARBOROUGH, ON, M1N-2M7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	April Beckett

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

To CVH (No. 1) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

Order # / Ordre no : 001

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

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, s. 19. (1).

Specifically, the licensee shall ensure that all residents are protected from abuse by anyone.

Upon receipt of this report the licensee shall prepare a plan to include but not be limited to:

1. a. Ensure additional training is provided to all supervisory staff and the staff who provide direct care to residents on:
- Abuse recognition
- Home's policy on zero tolerance of resident abuse with reference to the incidents identified in the inspection report.
- Duty to make mandatory reports under section 24
- Consequences for those who abuse or neglect residents
- Whistle-blowing protections

b. Provide leadership training for all supervisory staff including the registered nursing staff who are responsible to supervise the personal support workers (PSWs) in the unit.

Maintain the related training records for item# 1a and 1b including names of those attended, dates, who provided the education and training materials.

2. Conduct post-training evaluation for the staff to ensure comprehension of the training material and maintain the evaluation records.

3. Develop and implement a specific ongoing process to monitor:
a. The provision of care to residents
b. Staff to resident interactions
c. Deployment of staff to meet residents' needs – specifically to ensure sufficient staff are always available to provide care for residents requiring 2-person assistance as per their plan of care.

Maintaining written records for the monitoring process.

4. Develop and implement an on-going auditing process to ensure that the ongoing monitoring process is being carried out by the designated staff. Maintain a written record of the auditing process including the frequency of the audits, who will be responsible for doing the audits and evaluating the results. The written record must include the date and location of the audit, the resident's name, staff members audited, the name of the person completing the audit, the outcome and follow-up of the audit results.

Please submit the written plan for achieving compliance for inspection #: 2019_530726_0006 to Rebecca Leung, LTC Homes Inspector, MLTC, by email to TorontoSAO.MOH@ontario.ca by September 24, 2019. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was protected from abuse by anyone.

Under O. Reg. 79/10, s.2 (1), for the purpose of the definition, "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain.

Under O. Reg. 79/10, s.2 (2), for the purposes of the definition, 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.

The Ministry of Long-Term Care (MLTC) received a complaint from resident #001's SDM (#105) on an identified date regarding a staff to resident abuse.

SDM #105 reported concerns about resident #001's safety related to provision of care by the home's staff.

Critical Incident System (CIS) report was submitted to the MLTC related to a staff to resident physical abuse incident involving resident #001. A review of the CIS report indicated that the police was involved, and a staff member was charged on an identified date based on the videos provided by SDM #105. The home's management staff was informed by the police officers that there might be other staff involved in the incident.

In an interview, the administrator (#101) stated that SDM #105 went to them on an identified date to report concerns with resident #001's safety. However, SDM #105 refused to provide the administrator with any name of staff or date and time of any related incident. Administrator #101 stated that they were unable to initiate the investigation at that time. Administrator #101 confirmed that based on the information provided by the police officer and SDM #105 related to resident #001, they had suspended a specified number of staff from duties during the investigation nine days after SDM #105 first reported the incident to the home. In an interview, DOC #102 stated that intensive monitoring was implemented for resident #001 to ensure their safety.

In an interview, SDM #105 and SDM #106 stated that they were concerned with the unexplained altered skin integrity on resident #001's identified body parts. They had reported their concerns to the home's management staff about a month ago and the staff informed them about the possible cause for the resident #001's altered skin integrity and implemented specified interventions accordingly. SDM #105 and #106 were frustrated as the home did not take further action to address their concerns about resident #001's safety. SDM #105 informed the inspector that they had installed a surveillance camera inside resident #001's room and provided the inspector with a copy of a number of videos which were recorded within a specified date range. SDM #105 later agreed that the inspector could show the home's management team all the videos.

The inspectors then met with the administrator (#101) and Director of Care (DOC #102) on the identified dates to show them the videos provided by SDM #105. The administrator #101 and DOC #102 assisted the inspector to identify

the staff shown in the videos as they were watching the videos. At the end of the meetings, a number of staff involved in the incident were identified. The administrator #101 and DOC #102 acknowledged the following initial findings:
- As shown in some videos, one staff had physically abused resident #001.
- A number of the videos showed that some staff had used excessive force when providing the identified care for resident #001. Multiple staff had provided the identified care for resident #001 in bed by themselves. The rough handling could increase the shearing force leading to potential altered skin integrity.
- As shown in some videos, multiple staff should have requested another staff to assist with providing the identified care for resident #001 in bed as resident #001 required two-person assistance for bed mobility and the identified care.

The inspectors reviewed all videos provided by SDM #105 and identified multiple incidents in which resident #001 was physically abused by the staff including excessive force being used during provision of care. In some videos, registered staff was present and witnessed the incident, but did not stop the abuse and did not take action to protect the resident. The above-mentioned findings were acknowledged by the DOC and the administrator during interviews and at the exit debriefing.

Inspector #726 then conducted a record review for the specified date range and observation for resident #001 to determine the injury and/or pain caused to the resident, and resident's functional status and care needs:

a. A review of an identified assessment completed on an identified date, indicated that resident #001 was identified with some functional issues and required specified assistance with two persons for their identified activities of daily living (ADLs).

b. A review of resident #001's care plan indicated that under a focus of impaired skin integrity, some of the interventions included specified assistance with two persons for identified ADLs and the application of a specified protection device.

c. A review of a progress note for an identified date written by RPN #128, indicated that the assigned PSW reported a new altered skin integrity on an identified body part of resident #001. A review of resident #001's identified assessment for an identified date completed by RPN #128, indicated the

resident did not complain of pain related to the identified altered skin integrity. A review of an incident report for an identified date completed by RPN #128, indicated the predisposing factors included resident's identified skin condition and the incident might have occurred when resident went on leave of absence (LOA) with family. In an interview, SDM #105 stated that they were frustrated when the staff informed them regarding the new altered skin integrity that was observed on resident #001 and that, the staff assumed the altered skin integrity was caused by the family and did not initiate an investigation to identify the cause of the unexplained altered skin integrity.

d. A review of resident #001's specified notes from assessment for an identified date written by RPN #128, indicated that an altered skin integrity was observed on an identified body part.

e. A review of resident #001's specified notes from assessment for an identified date written by RPN #128, indicated that altered skin integrity was observed in other identified body parts.

f. A review of resident #001's specified notes from assessment for an identified date written by RPN #127, indicated that new and old altered skin integrity of different types were observed in various body parts.

g. On an identified date, the inspector observed altered skin integrity on multiple identified body parts of resident #001, and some of them appeared to be resolving.

h. A review of the specified assessments completed within a specified date range, indicated resident #001's was in no pain most of the time, and in mild pain for a specified number of days.

i. A review of the medication administration record for an identified month, indicated resident #001 was on an identified medication with specified dosage and frequency for pain since an identified date. In an interview, RPN #128 stated that resident #001 was taking the identified medication for the pain related to the altered skin integrity in the identified body parts.

In the interviews, PSW #121 and #125 stated that sometimes when they

provided the identified care for resident #001 alone because other staff were not available to help them.

In the interviews with the staff involved - PSWs #117, #118, #119, #120, #121, #122, #123, #124, #125, and #126, and RPN #127 and #128, they confirmed their awareness of the home's policy on promoting zero tolerance of abuse and neglect and acknowledged the use of excessive force during provision of care would be considered a form of physical abuse.

A review of the nursing progress note indicated that resident #001 was discharged and transferred to another long-term care home on an identified date.

Please refer to the grounds provided for Compliance Order #003 issued pursuant to LTCHA, s. 75. (2).

Please refer to the grounds provided for Written Notification #5 issued pursuant to LTCHA, s. 6 (7).

During the review of the videos provided by SDM #105, the inspectors identified multiple incidents related to staff to resident physical abuse and use of excessive force during provision of care. It is noted that all the video recordings except two, did not have audio and therefore inspectors could not hear the residents' reaction. During the record review, the inspector identified documentation of specified altered skin integrity written by the registered staff. The inspector also observed identified altered skin integrity on the resident on the first day of inspection. The licensee has failed to ensure that resident #001 was protected from physical abuse by the staff. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection of the LTCHA that included:
- Voluntary plan of correction (VPC) issued Dec 5, 2016 (2016_377502_0015)
- Compliance order (CO) issued Oct 10, 2017 with a compliance due date of Nov 10, 2017 (2017_632502_0012)

- Compliance order (CO) issued Sep 21, 2018 with a compliance due date of Dec 12, 2018 (2018_630589_0009)
(726)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 06, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 36.

Specifically, the licensee shall ensure that all staff use safe transferring and positioning devices or techniques when assisting residents #002, #003 and all other residents in the home.

Upon receipt of this report the licensee shall prepare a plan to include but not be limited to:

1. Provide additional training to all registered nursing staff and personal support workers on:
a. Safe transferring of resident from wheelchair to bed using the specified transferring equipment including proper application of the specified transferring device on the resident prior to initiation of transfer.
b. Use of safe and proper positioning devices and techniques when assisting residents with positioning and repositioning in bed, and transferring using the specified transferring equipment or the specified transferring technique.
c. The importance for staff to follow the relevant guidance and instructions specified in individual resident's care plan, specifically the number of staff required for assisting the individual resident for positioning and repositioning in bed and transferring using the specified transferring equipment or the specified transferring technique to ensure resident safety.

Maintain the related training records including names of those attended, dates, who provided the education and training materials.

2. Conduct post-training evaluation for the staff to ensure comprehension of the

training material and maintain the evaluation records.

3. Develop and implement an on-going auditing process to ensure that all staff are using safe transferring and positioning devices or techniques when assisting residents the home. Maintain a written record of the auditing process including the frequency of the audits, who will be responsible for doing the audits and evaluating the results. The written record must include the date and location of the audit, the resident's name, staff members audited, the name of the person completing the audit, the outcome and follow-up of the audit results.

Please submit the written plan for achieving compliance for inspection #: 2019_530726_0006 to Rebecca Leung, LTC Homes Inspector, MLTC, by email to TorontoSAO.MOH@ontario.ca by September 24, 2019. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents #001, #002 and #003.

A complaint was submitted to the MLTC on an identified date, regarding family member's concerns after watching videos from a video camera that the family had been set up at resident #001's bedside. The family members who are Substitute Decision Makers (SDM) identified physical and verbal abuse by staff to resident #001 and they notified the home.

A review of resident #001's identified assessment for an identified date, indicated that resident #001 had some identified functional issues requiring specified assistance with two persons for their identified ADLs. Review of an identified assessment for an identified date, indicated that the therapist identified that the resident had specified functional issues and needed specified assistance with two persons for bed mobility, transfer and all basic ADLs. A review of resident #001's written plan of care revised last on an identified date, under focus section for bed mobility, transfer, and ADLs, identified that the resident needed specified assistance with two persons for personal care. The written plan of care also guided the staff to provide a specified care on a specified time interval for an identified altered skin integrity on the resident. The

resident had a specified therapeutic device to promote the healing of an identified altered skin integrity.

A review of the videos for an identified date range indicated the following:
- On a number of occasions, only one staff provided care to resident #001, for identified ADLs and bed mobility instead as the plan of care indicated, two staff to provide care for the identified ADLs.
- The staff did not use safe positioning techniques when they repositioned resident #001 and when they turned the resident during provision of care.
- Two staff identified by DOC as PSW #122 and PSW #125 were observed transferring resident #001 using a specified transferring equipment with unsafe transferring technique.
- One PSW tried to apply a specified transferring device to resident #001 while the resident was sitting in a wheelchair. The PSW pulled the resident forward standing in front of the resident and tried to reach at the back of the resident to apply the specified transferring device as low behind the resident's back as possible.
- Transfer of resident #001 from bed to a wheelchair by two staff, one identified as PSW #122 who was trying to connect the specified transferring device to the specified transferring equipment while the equipment, with the resident in the specified transferring device was in motion.
- One staff identified by the DOC as PSW #120 and an unidentified staff repositioned the resident after the resident slid low in the bed. The staff grabbed the resident under their arms and slid them higher up in the bed with head of the bed still elevated, placing the resident at risk for impaired skin integrity.
- Used unsafe technique when one staff turned the resident from side to side, pulling off a therapeutic device that the resident had attached.
- Two staff identified by the DOC as PSW #122 and PSW #116 repositioned the resident in bed by grabbing the resident's upper extremities and pulling the resident up, while the head of the bed was still elevated to a resting position.
- Review of another number of videos showed unsafe repositioning and improper positioning technique of the resident provided by either one or two staff as identified by the DOC by names and their titles. The identified PSWs would grab resident's upper extremity and another part of the body, indicated to be the resident's lower extremity and would lift them and carry over the resident's body to the other side of the bed, then quickly pushing the resident's back to ensure that the resident stayed all the way on the other side. It was particularly

challenging for one staff.

Interviews with all the staff identified on the videos, confirmed that resident #001 needed a specified assistance by two staff for identified ADLs and bed mobility. They also confirmed that the resident needed specified assistance with two staff for continence care. Further, the PSWs acknowledged that during provision of care to resident #001, because they did not always have a second person for assistance, they were not able to provide proper transfer and positioning.

In an interview with the DOC after reviewing the videos, the DOC confirmed that the staff identified in the videos did not use safe transferring and positioning devices or techniques when assisting resident #001. (600)

2. An observation conducted in resident #002's room on an identified date, indicated that resident #002 had been transferred from bed to a wheelchair by PSW #110 using a specified transferring equipment. It was observed the PSW was removing the specified transferring equipment away from resident #002 who was sitting in a wheelchair in their room. The PSW indicated that RPN #112 came and assisted them to transfer the resident using the specified transferring equipment.

A review of resident #002's identified assessment for an identified date, and written plan of care indicated that the resident was at an identified cognitive functional status. The written plan of care also indicated that the resident had been complaining of identified symptoms in specified body parts. The plan of care guided the staff to use specified assistance by two staff for transfers with a specified transferring equipment.

Interview with RPN #112 stated that they did not assist PSW #110 during the transfer with the specified transferring equipment that morning.

In an interview resident #002 indicated that many times only one staff transferred them, and when they are short, they work faster than is safe and that it was worrying. Further, the resident stated that this morning, PSW #110 was alone when they transferred them from bed to a wheelchair using the specified transferring equipment.

An interview with the DOC indicated that staff is expected during every transfer with specified transferring equipment, to be completed by two staff. Further the DOC explained that PSW #110 should not transfer the resident alone using the specified transferring equipment, but to ask for assistance of a second staff. The PSW was re-educated on how to complete safe transferring when assisting residents. (600)

3. An observation conducted on an identified date, in resident #003's room identified that resident #003 had been transferred with a specified transferring technique from wheelchair to a toilet by PSW #110 and RPN #112. The PSW indicated that the RPN assisted them to transfer the resident from wheelchair to the toilet, and the RPN confirmed that they transferred the resident with the specified transferring technique.

The written plan of care stated two staff to use a specified transferring equipment, to transfer the resident from wheelchair to a commode and vice versa using specified assistance.

An interview with PSW #110 indicated that the resident requested to go to the toilet and the specified transferring equipment was not available at that time, so they transferred the resident by two-person using the specified transferring technique. In an interview with the RPN, they stated that resident #003 needed specified assistance for transfer using a specified transferring equipment by two staff for safety, but at the time the specified transferring equipment was not available, so they transferred the resident using the specified transferring technique.

In an interview, the DOC stated that the staff had to provide safe transfer and in this case, they should use another specified transferring equipment if the specified transferring equipment was not available and that, specified transferring technique was not safe. [s. 36.]

The severity of this issue was determined to be a level 3 as there was actual risk to resident #001, #002 and #003. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 2 compliance history as they had no previous non-compliance to the same subsection of the LTCHA. (600)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 : Dec 06, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

Order # / Ordre no : 003

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

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, s. 75 (2).

Specifically, the licensee shall ensure that screening measures including police record checks are conducted in accordance with the regulations before hiring staff.

Upon receipt of this report the licensee shall prepare a plan to include but not be limited to:

1. Ensure the police record checks are conducted for the involved PSWs as identified in the inspection report and all staff who do not currently have a criminal record check.

2. Develop and implement a process to ensure the police record checks are conducted before hiring staff.

3. Develop and implement an on-going auditing process to ensure that the police record checks are conducted before hiring staff. Maintain a written record of the auditing process including the frequency of the audits, who will be responsible for doing the audits and evaluating the results. The written record must include the date and location of the audit, the resident's name, staff members audited, the name of the person completing the audit, the outcome and follow-up of the audit results.

Please submit the written plan for achieving compliance for inspection #: 2019_530726_0006 to Rebecca Leung, LTC Homes Inspector, MLTC, by email to TorontoSAO.MOH@ontario.ca by September 24, 2019. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that screening measures including police record checks were conducted in accordance with the regulations before hiring staff.

A review of the personal folders of the involved PSWs, indicated that police record checks were not conducted for some of the PSWs before or after they were hired, and one PSW had police record check conducted after hiring.

In an interview, the DOC #102 acknowledged that the home should have conducted the police record checks for all PSWs prior to hiring. [s. 75 (2)]

The severity of this issue was determined to be a level 3 as there was actual risk to resident #001. The scope of the issue was a level 2 as it related to six of ten involved staff reviewed. The home had a level 2 compliance history as they had no previous non-compliance to the same subsection of the LTCHA. (726)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 06, 2019

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 Health and 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:

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 Health and 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 de la Santé et 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 de la Santé et 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 10th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Rebecca Leung

Service Area Office /
Bureau régional de services : Toronto Service Area Office