Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

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


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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 10, 2020 | 2020_822613_0011 | 008299-20, 010158-20 | Complaint |

## Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Van Daele
39 Van Daele Street SAULT STE. MARIE ON P6B 4V3

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

LISA MOORE (613)

## 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): June 8 - 12 and 15 - 17, 2020.**

**The following complaint were inspected during this inspection:**

**Two Complaints that were submitted to the Director regarding numerous concerns regarding the provision of care and safety to residents, infection control and prevention practices and allegations of abuse and neglect.**

**During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Assistant Director of Care (ADOC), Dietary Manager (DM), Resident Assessment Instrument Coordinator (RAI Coordinator), Housekeeping Aide (HA), Resident Assistant (RA), Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Behavioural Supports Ontario Personal Support Worker (BSO PSW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.**

**The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed written compliant letters, personnel files, health care records, and policies, procedures and programs.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Infection Prevention and Control**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Responsive Behaviours**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

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

**s. 23. (1) Every licensee of a long-term care home shall ensure that,**
**(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
**(i) abuse of a resident by anyone,**
**(ii) neglect of a resident by the licensee or staff, or**
**(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
**(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
**(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every alleged, suspected or witness incident of neglect of a resident by the licensee or staff that the licensee knows of, or that was reported to the licensee was immediately investigated and that appropriate action was taken in response to every such incident.

Neglect is defined in the O. Reg. 79/10 as the failure to provide a resident with the treatment, care, series or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #613 reviewed two Complaint reports that were submitted to the Director, identifying concerns regarding the provision of care and safety to the residents and allegations of abuse and neglect.

A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" (RC-20-02-03) last updated June 2020, identified that all reported incidents of abuse and/or neglect would be objectively, thoroughly and promptly investigated, ensuring that reporting requirements to provincial and regulatory bodies had been completed as required, enforcing appropriate consequences for those responsible for abuse or neglect of residents and ensuring that a copy of the documentation and all other evidence collected was stored with in a secure area of the home. The policy further stated that Extendicare was committed to providing a safe and

secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. Extendicare had a zero tolerance for abuse and neglect by any person, whether through deliberate acts or negligence would not be tolerated.

A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" (RC-02-01-02) last updated June 2020, identified that the Administrator or delegate was to immediately initiate an investigation of the alleged, suspected or witnessed abuse. All staff were to immediately respond to any form of alleged, potential, suspected or witnessed abuse or neglect.

The Inspector met with the Administrator (ADM) and Assistant Director of Care (ADOC) and requested all written compliant letters that were submitted by staff concerning improper and incompetent treatment or care of residents and allegations of abuse and neglect. They provided the Inspector with four letters dated on specific dates and two that were both dated on the same date. The ADOC also provided four personnel files to the Inspector and stated, "there may be some letters of concerns in these files".

A review of the four written complaint letters that were submitted by staff concerning improper and incompetent treatment or care of residents and allegations of abuse and neglect identified the following:

A) A letter dated on a specific date, identified resident safety and care concerns for a specific date on a specific shift, alleging improper/incompetent care provided by staff, specifically indicating residents were being transferred without the use of specific equipment or without two staff members, not putting beds into the low position or using falls prevention interventions while residents were in their beds, residents being provided with the wrong diet type and/or texture, residents not receiving peri care during continence product changes and/or not receiving continence product changes and put to bed wet and/or soiled. This letter indicated that RN #117 was notified of the improper and incompetent care and the neglect of resident care on the dates they occurred and that this letter of concern was provided to the Administrator (ADM) on a specific date.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no further documentation to identify that RN #117 had reported the allegations of improper and incompetent care and the neglect of resident care immediately to management, or that the Director had been immediately notified or that an investigation had immediately commenced, and there was no outcome of the

investigation or what corrective actions had occurred to prevent recurrence.

B) A letter dated on a specific date, identified allegations of abuse from Dietary Aide (DA) #113 towards resident #007 and identified other resident rights and safety concerns for two dates on a specific shift. This letter alleged that DA #113 had not allowed residents to have coffee during their meal service and were told they could only have it before or after the meal; directing residents to enter the dining room using one door, which was a far distance for residents to ambulate, not allowing them to use the entrance in their hallway and speaking to residents in an inappropriate tone. The written letter indicated on a specific date, resident #007 reported to RPN #107 that DA #113 spoke to them in a tone of voice they had not appreciated, describing the DA's tone of voice as "gruff, coarse and insistent". The letter also indicated concerns of residents being transferred into chairs, toilets and tub and then the resident's being left unattended, which was against the interventions in their care plans.

The Inspector requested the internal investigation file and was provided with the investigation notes that were started by the Dietary Manager (DM) #100 on a specific date, indicating this incident was not immediately investigated, but rather the investigation commenced three days after the DA became aware of the allegations of abuse. The investigation notes indicated that DM #100 had only spoken to staff and had not spoken to DA #113 or the resident involved. There was no further documentation to identify that the Director had been immediately notified or that DA #113 had been removed from the schedule pending the investigation and there was no outcome of the investigation or what corrective actions that had occurred to prevent recurrence.

C) A letter dated on a specific date, identified resident neglect concerns alleging residents were not having their continence care products changed and were being left in their continence products from two shifts prior, with unused products and cloths from the previous shift found in the resident's bedside table. The letter identified that residents were found soaked in urine to their clothing and that RNs #109 and #110 and RPNs #106 and #107 were aware of the allegations of neglect. The letter was provided to the ADM on a specific date.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no documentation to identify that RN #109, RN #110 or RPN #106 had reported the allegations immediately to management, that the Director had been immediately notified or that an investigation had immediately commenced, and there was no outcome of the investigation or what corrective actions had occurred to

prevent recurrence.

D) Another letter dated on a specific date, identified ongoing concerns of resident neglect that had been occurring since April 2020 and that the ongoing concerns of improper and incompetent care and neglect of resident care were reported to various RNs and Management previously. The letter expressed concerns of residents being soaked in urine to their continence care products and clothing or sitting in soiled continent products and wearing the same continent product from the previous two shifts and that the previous shift continence care products and cloths had been found in the resident's bedside tables untouched, residents not having clothing changed and remaining in their night clothes from two shift prior, residents not being repositioned as per their care plans, and allegations that a resident had not been showered for two weeks. This letter identified concerns specifically to the neglect and lack of care provided by PSW #115 from the prior day shift. The letter was provided to the ADM on a specific date.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no documentation to identify that RN #109, had reported the allegations immediately to management, that the Director had been immediately notified or that an investigation had immediately commenced, and there was no outcome of the investigation or what corrective actions had occurred to prevent recurrence.

A review of PSW #115's personnel file did not have any follow up documentation to verify that the allegations of ongoing concerns of improper and incompetent care and neglect of residents' care had been addressed with corrective action to prevent recurrence.

E) The Inspector reviewed another staff member's personnel file, PSW #116, that was provided by the ADOC. This personnel file contained letters of concern submitted by staff members alleging concerns of resident safety, improper or lack of care, and neglect of resident care by PSW #116, for three different occurrences. A letter dated on two specific dates, indicated concerns regarding resident safety, improper or lack of care, not following resident care plan and neglect of resident care by PSW #116. The letter contained allegation of inappropriate transferring of residents without the use of equipment or the assistance of another staff member, not providing care to residents at a specific time, not changing resident's continence care products in a timely manner and leaving a resident in soiled clothing with stool on their hand and clothing, after a continence care product change. The letter identified that RPN #107 had reported their concerns to RN #110 on a specific date, but had not reported their concerns from one of the dates immediately.

A review of a letter dated on a specific date, signed by RN #110, indicated that RPN #107 had informed them of the multiple concerns regarding resident safety, improper and/or lack of care, not following resident care plans and neglect of resident care by PSW #116 on a specific date. This letter identified that RN #110 sent PSW #116 home immediately after being notified of the care concerns but did not report the allegations immediately to the on-call Manager, rather RN #110 wrote a letter of the concerns and provided it to the Director of Care (DOC), who received the letter on the following business day.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no documentation to identify that the Director had been immediately notified or that an investigation had immediately commenced, and there was no outcome of the investigation or what corrective actions had occurred to prevent recurrence.

F) Another letter in PSW #116's personnel file, dated on a specific date, identified it was submitted to the Director of Care (DOC) on the same date, by RPN #107, indicating several concerns of resident safety, improper and/or lack of care provided to the residents, not following resident care plans and neglect of resident care provided by a staff member. There was no specific staff member identified, but the care concerns were improper and unsafe transferring, residents being provided the wrong diets, resident's continence care products not being changed, bedtime care or scheduled baths/showers were not being provided, not following individualized resident care plans, residents not being repositioned and infection control issues.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no documentation to identify that the Director had been immediately notified or that the DOC had immediately commenced an investigation, and there was no outcome of the investigation or what corrective actions had occurred to prevent recurrence.

G) Another letter in PSW # 116's personnel file, dated on a specific date, indicated concerns of resident safety, improper and/or lack of care provided to the residents, not following resident's care plans and neglect of resident care on two specific dates, by PSW #116. This letter alleged putting residents to bed then leaving the resident's beds in the high position, moving and transferring a resident post fall without an assessment from a registered staff member, transferring a resident to bed alone that required the use

changes, providing the wrong type of diet to residents for their snack and other infection control concerns. There were also two letters titled, “Performance Correction Notice” written by RN #117, dated on two specific dates, identifying these letters had been provided to management. The letters identified concerns with PSW #116, transferring residents without a mechanical lift, not using dietary sheets when providing meals/snacks to the residents, not following resident care plans, not providing peri care during continence care product changes and other infection control issues. There was no documentation to identify if RN #117 had spoken to PSW #116, or the date when RN #117 provided letters to management or to which manager.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no further documentation to identify that the Director had been informed of the improper and incompetent care, that the ADOC immediately commenced an investigation, as DOC was on a LOA, and no outcome of the investigation or what corrective actions had occurred to prevent recurrence.

A review of the Long-Term Care Homes reporting portal did not identify any critical incident reports related to the allegations of improper or incompetent treatment or care or the residents or verbal abuse and neglect of the residents.

During interviews with PSW#101, PSW #105 and RPN#106, they all stated they were aware of resident care, neglect and safety issues occurring on a specific unit. The care staff stated that the concerns have been occurring since March 2020 and were ongoing. The care staff further stated that they had reported their concerns to the registered staff, ADOC or ADM either verbally, via telephone message or in writing via email at the time they had occurred.

During an interview with RN #109 and #110, they both stated they were aware of care issues occurring on the floor, such as residents being left in their continence care products from the previous two shift, residents not being showered, residents being left in their wheelchairs all shift and not being repositioned. Both RNs stated they had not reported the improper or incompetent resident care concerns or the allegations of neglect to management. All staff stated that they were trained on zero tolerance of abuse and neglect annually.

During an interview with the ADOC, they stated that they had not commenced an investigation into the letters of concerns, at the time of the inspection, and still had to speak with staff. The ADOC stated that several RNs did not follow up or complete an

investigation to the care concerns at the time they were brought to their attention and they did not report to management immediately. They further stated they were aware of performance issues by PSW #115 and PSW #116. The ADOC stated they had to set up a meeting to speak with PSW #115 and that PSW #116 had been moved to a different work assignment.

A review of PSW #115 and PSW #116's personnel file did not indicate any recent coaching or discipline had occurred.

During an interview with the ADM, they stated that there was no documentation to support that an investigation or appropriate action had occurred for each reported incident. They further stated they expected an investigation to occur immediately when suspected, alleged or witnessed abuse/neglect occurred. The ADM stated that when they received a written complaint letter from staff involving resident care concerns or safety issues or allegations of abuse or neglect, they forward the letter to the DOC, ADOC or department manager on the same date it was received. The ADM stated they expected the manager to create a folder and commence an investigation immediately and notify the Director when suspected, alleged or witnessed abuse or neglect occurred. The ADM confirmed that staff did not comply with the licensee's zero tolerance of abuse and neglect policy and that no incident had been reported to the Director.

Various care staff members and management were aware of the numerous occurrences of improper and incompetent care and allegations of abuse and neglect that were putting the residents at risk from March 2020 to June 2020, and they did not comply with the procedures of the licensee's policies for zero tolerance of resident abuse and neglect; therefore, the licensee has failed to protect all residents from abuse and neglect by not investigating immediately and taking appropriate action in response to every such incident. [s. 23. (1) (b)]

***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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that when improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #613 reviewed two Complaint reports that were submitted to the Director, identifying concerns regarding the provision of care and safety to the residents and allegations of abuse and neglect.

The Inspector met with the Administrator (ADM) and Assistant Director of Care (ADOC) and requested all written compliant letters that were submitted by staff concerning improper and incompetent treatment or care of residents and allegations of abuse and neglect. They provided the Inspector with four letters dated on specific dates and two that were both dated on the same date. The ADOC also provided four personnel files to the Inspector and stated, "there may be some letters of concerns in these files".

A review of the four letters received identified concerns of resident safety, improper or lack of care, allegations of abuse and neglect of resident care occurring from March to June 2020. See WN #1 for specific details.

A review of the personnel files, identified that there were four additional letters submitted

by staff, alleging concerns of resident safety improper or lack of care, verbal and neglect of resident care by PSW #116 and other staff occurring from March to April 2020. See WN #1 for specific details.

A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" (RC-02-01-02) last updated on June 2020, identified that staff must complete an internal incident report and notify their supervisor (or during after-hours the nurse on site). The nurse would then call the Manager on-call immediately upon suspecting or becoming aware of abuse or neglect of a resident. Management would promptly and objectively report all incidents to external regulatory authorities.

A review of the Long-Term Care Homes reporting portal did not identify any critical incident report related to the allegations of improper or incompetent treatment or care or the residents or verbal abuse and neglect of the residents.

During an interview with RN #109 and #110, they both stated they were aware of care issues occurring on the floor, such as residents being left in their continence care products from the previous two shift, not being showered, being left in their wheelchairs all shift and not being repositioned. Both RNs stated they had not reported the neglect allegations or the improper or incompetent care concerns to management. RN #109 stated they did not have time to write out a report for management and RN #110 stated they thought the care staff was going to report the care concerns to management.

During interview with ADOC, they confirmed that the Director had not been informed immediately for any of the written complaints regarding improper or incompetent treatment or care of a resident or abuse or neglect care concerns.

During an interview with the ADM, they stated the Director had not been notified immediately for any of the written complaints regarding improper or incompetent treatment or care of a resident or abuse or neglect care concerns.

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that when abuse of a resident by anyone or neglect of a resident that resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #613 reviewed two Complaint reports that were submitted to the Director,

identifying concerns regarding the provision of care and safety to the residents and allegations of abuse and neglect.

The Inspector met with the Administrator (ADM) and Assistant Director of Care (ADOC) and requested all written compliant letters that were submitted by staff concerning improper and incompetent treatment or care of residents and allegations of abuse and neglect. They provided the Inspector with four letters dated on specific dates and two that were both dated on the same date. The ADOC provided four personnel files to the Inspector and stated, “there may be some letters of concerns in these files”.

A review of the written letter of concern dated on a specific date, identified allegations of abuse from Dietary Aide (DA) #113 towards resident #007. The written letter of concern indicated on a specific date, resident #007 reported to RPN #107 that Dietary Aide #113 spoke to them in a tone of voice they had not appreciated, describing the DA’s tone of voice as “gruff, coarse and insistent”.

Verbal abuse is defined in the O. Reg. 79/10 as any form of communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other then a resident.

A review of the licensee’s policy titled, “Zero Tolerance of Resident Abuse and Neglect: Response and Reporting” (RC-02-01-02) last updated on June 2020, identified that management would promptly and objectively report all incidents to external regulatory authorities

A review of the residents’ progress notes indicted that resident #007 was upset about the way he was spoken to by DA #113, describing their tone of voice as “gruff, coarse and insistent”. The resident requested that a management team member be made aware.

A review of the Long-Term Care Homes reporting portal did not identify any critical incident report related to the allegations of verbal abuse.

During an interview with the Dietary Manager #100, they stated that the way DA #113 had spoken to resident #007 was verbal abuse and confirmed that they had not reported the allegations of verbal abuse to the Director.

During an interview with the Administrator, they confirmed that the allegations of abuse

had not been reported to the Director immediately by the Dietary Manager. [s. 24. (1)]

***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. 20. Policy to promote zero tolerance**

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

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect was complied with.

Inspector #613 reviewed two Complaint reports that were submitted to the Director, identifying concerns regarding the provision of care and safety to the residents and allegations of abuse and neglect.

The Inspector met with the Administrator (ADM) and Assistant Director of Care (ADOC) and requested all written compliant letters that were submitted by staff concerning improper and incompetent treatment or care of residents and allegations of abuse and neglect. They provided the Inspector with four letters dated on specific dates and two that were both dated on the same date.

A review of the written letter on a specific date, identified allegations of abuse from Dietary Aide (DA) #113 towards resident #007. The written letter of concern indicated on a specific date, resident #007 reported to RPN #107 that DA #113 spoke to them in a tone of voice they had not appreciated, describing the DA's tone of voice as "gruff, coarse and insistent".

A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" (RC-02-01-03) last updated June 2020, identified that the Manager would immediately advise the employee that they were being removed from the work schedule, with pay, pending an investigation.

A review of the resident's progress notes indicted that resident #007 was upset about the way he was spoken to by DA #113, describing their tone of voice as "gruff, coarse and insistent". The resident requested that a management team member be made aware.

During an interview with the Dietary Manager #100, they showed the Inspector the DA's work schedule and stated that DA #113 had worked a scheduled shift, following the reported incident on May 31, 2020. The DA confirmed that they had not spoken to the DA or removed them from the from the work schedule after being notified of the allegations of abuse and while pending an investigation.

During an interview with the ADM, they confirmed that DA #113 had not been removed form the work schedule immediately and that they had informed the DA that they were not permitted to return to work until the investigation was completed. [s. 20. (1)]

***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 O.Reg 79/10, s. 33. Bathing**

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

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements.

O. Reg. 79/10, s. 33 (2), states for this section "bathing" includes tub baths, showers and full body sponge baths.

Inspector #613 reviewed a Complaint report that was submitted to the Director, identifying resident #003 had not been bathed for a two week time period.

A review of the licensee's policy titled, "Bathing" (RC-06-01-02) last updated June 2020, identified each resident would receive a tub bath or shower and would be offered a tub bath or shower, based on resident preference, twice per week at minimum. Refused bathing would be documented on the daily care record (or electronic equivalent) as well as alternate interventions utilized to promote the resident's comfort and hygiene.

A review of the resident's care plan indicated that the resident preferred a specific type of bathing on two specific dates weekly.

RAI Coordinator #114 provided the Inspector with the resident #003's Point of Care (POC) documentation for bathing for March, April, May and June 2020. The RAI Coordinator highlighted seven dates that there was no documentation on POC for bathing.

There was no documentation for two dates in March 2020 and five dates in April 2020.

A review of the "Point of Care Audit Report" identified that bathing had not been completed for resident #003 on six of the above identified dates, except it did not identify one date in March 2020.

A review of the POC and the progress notes documentation did not identify that a bed bath had been provided to resident #003 on any of the identified dates.

During various interviews with PSW #101, PSW #105, RPN #106 and RPN #108, they all stated that the method of bathing for a resident was to be documented and if it is not documented, the care was not provided. They all indicated that if a resident refused or was palliative, they were to receive a bed bath.

During an interview with RN #109, they stated they were aware that resident #003's bathing was not documented for a while, but they had been informed by PSW #115 that a bed bath had been provided. The RN confirmed they had not documented in the progress notes that bed baths had been provided on the seven dates that there was no documentation on POC.

During an interview with the ADOC, they stated that if there was no documentation on POC for bathing, it meant that the care was not done. The ADOC stated a resident was to be bathed twice per week as per their care plan and staff needed to document what type of bathing was completed. The ADOC stated that resident #003's status had deteriorated during this time, but they still should have received a bed bath. They further stated that the PSW should be informing the registered staff if the resident refused or if a bed bath was provided, so that the care provided was documented. [s. 33. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, to be implemented voluntarily.***

---

**WN #5: 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 resident #004.

Inspector #613 reviewed a Complaint report that was submitted to the Director, identifying resident #004 had been transferred inappropriately by RPN #108 and RPN #106.

A review of the licensee's policy titled, "Safe Lifting with Care Program" (LP-01-01-01) last updated on June 2020, identified that, Extendicare was a zero-lift facility and that the zero lift was now integrated with the safe lifting with care program. The zero-lift system was designed to eliminate all manual resident lifting and handling through the use of appropriate devices, for the purpose of improving resident quality of life and reducing injuries to staff. All breaches of the Mechanical Lift policy or procedure would result in an investigation and may result in progressive discipline up to an including termination.

A review of resident's Resident Assessment Instrument-Minimum Data Set (RAI-MDS) at the time of the improper transferring, identified that the resident used a mobility device as their primary mode of transportation with assistance.

A review of the resident's care plan also identified resident #004 required assistance for all transfers and use of a mobility device with assistance by staff to move from location to

location on the unit.

A review of the progress notes did not identify any incident that resident #004 had been transferred inappropriately by RPN #108 and RPN #106.

During an interview with RPN #108, they stated that resident #004 was seated in a stationary chair and refused to transfer into their mobility device to attend a meal service. RPN #108 confirmed they and RPN #106 had transferred resident #004 while the resident was seated in the chair, lifting the chair off the floor slightly and carrying them into the dining room. The RPN stated that the resident displayed responsive behaviours during the transfer.

During an interview with RPN #106, they confirmed that they and RPN #108 had picked up the chair that resident #004 was sitting in and carried them into the dining room to attend their meal. RPN #106 stated resident #004 was hovering over the floor while seated in the chair during the transfer. The RPN stated that the resident was displaying responsive behaviours and could not be left alone while sitting in the stationary chair. RPN #106 stated the resident displayed responsive behaviours during the transfer to the dining room.

During interview with RPN #108 and RPN #106, they both stated that they had received training on safe transferring with care and mechanical lifts in 2019 and confirmed that the home had a zero-lift policy. Both RPNs stated that they had not provided safe transferring techniques to resident #004, and that they should not have manually lifted resident #004 while they were seated in a chair and transferred them to the dining room. Both RPNs were unable to provide a date that this incident occurred and that they did not document the incident in the progress notes.

During an interview with ADOC, they were unaware that this incident had occurred. The ADOC confirmed that RPN #108 and RPN #106 did not provide safe transferring techniques for resident #004 and that they did not follow the home’s zero-lift policy. [s. 36.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #004 and all other residents, to be implemented voluntarily.***

---

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

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

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001 who was unable to toilet independently some or all of the time received assistance form staff to manage and maintain continence.

Inspector #613 reviewed two Complaint reports that were submitted to the Director, identifying resident #001 witnessed on a specific shift wearing a continence care product that was saturated with urine or soiled with stool on several occasions, alleging resident had not received peri care or product changes from the previous two shifts.

A review of the licensee's policy, "Continence Management Program" (RC-14-01-01) last updated December 2019 identified that care staff would provide resident with the support and or assistance they required to improve maintain or prevent deterioration of current functioning, maximize independence and promote comfort and privacy and maintain dignity. Including following a resident's care plan and completing all relevant and required documentation and verify documentation accuracy.

A review of the licensee's policy titled, "Daily Personal Care and Grooming" last updated

on June 2020, identified care staff would provide peri care based on assessed need and also when changing clothing or bedding to prevent skin irritation from prolonged contact with urine and care staff was required to report to the nurse if care was refused or not given.

A review of resident's Resident Assessment Instrument-Minimum Data Set (RAI-MDS) indicated that resident was incontinent.

A review of the resident's care plan identified that resident #001 was incontinent and would receive the necessary assistance with continence care every shift.

A review of the resident's progress notes identified three dates that resident #001 was found still wearing a soiled continence care product from the two shifts prior.

RAI Coordinator # 114 provided the Inspector with resident #001's Point of Care (POC) documentation for Elimination (April, May and June 2020) and stated these sheets show if resident had bladder or bowel movement and what care was provided.

Inspector #613 and the RAI Coordinator reviewed the documentation and they confirmed that there was no documentation on three specific dates. The RAI Coordinator confirmed that if there was no documentation on a date that it indicated that the care was not provided.

During interview with #105, they stated they worked a specific shift and have received resident #001 wearing a soiled continence care product from two shifts prior, on several occasions. PSW #105 stated sometimes the continence care product was falling apart because it was saturated with urine. PSW #105 informed the Inspector that hand towels, peri towels, face cloths and the resident's two continence care products that were assigned to a specific shift have been observed tucked under the resident's blanket on their bed or in the drawer of the resident's bed side table. The PSW stated resident #001 and other residents are found soaked in urine and without their continence care products changed when PSW #115 has worked the shift prior.

During various interviews with PSW #105, PSW #101and RPN #106, they stated they were aware of resident #001 having been left in a specific type of continence care product from the previous two shifts on several occasions. They all stated that resident #001's care plan had not been followed to ensure proper care and continence care product changes occurred.

During an interview with RN #109 and #110, they both stated they were aware of residents being left in a specific type of continence care product from the previous two shifts. Both RNs stated they had not reported the improper or incompetent resident care of the allegations of neglect to management. .

During an interview with the ADOC, they stated that resident #001 should not be left in a specific type of continence care product form the previous two shifts. The ADOC further stated that staff should be changing resident's continence care products as per their care plans and when there was no documentation on POC, it meant that the required care was not provided. [s. 51. (2) (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 resident #001 and all other residents who are unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence, to be implemented voluntarily.***

---

**Issued on this 10th day of July, 2020**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | LISA MOORE (613) |
| **Inspection No. / No de l'inspection :** | 2020_822613_0011 |
| **Log No. / No de registre :** | 008299-20, 010158-20 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Jul 10, 2020 |
| **Licensee / Titulaire de permis :** | Extendicare (Canada) Inc.<br>3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9 |
| **LTC Home / Foyer de SLD :** | Extendicare Van Daele<br>39 Van Daele Street, SAULT STE. MARIE, ON, P6B-4V3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Mary Deschene |

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

---

**Order # / No d'ordre :** 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. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

**Order / Ordre :**

The licensee must be compliant with s. 23 (1) (a) and (b) of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff or anything else provided for in the regulations is immediately investigated and appropriate action is taken in response to every such incident by the Registered Nurse on duty and the Management staff.

This plan must include, but is not limited, to the following:

(A) Identifying who will be responsible for the immediate implementation to ensure investigations are conducted immediately and appropriate follow through and action is taken in response to every such incident.

(B) Create an on-going auditing process to determine the efficacy of action taken in response to every such incident of alleged, suspected of witnessed abuse and neglect.

(C) Include who will be responsible for doing the audits and evaluating the results.

Please submit the written plan for achieving compliance for #2020_822613_0011 to Lisa Moore, LTC Homes Inspector, MOLTC, by email to SAO.generalemail@ontario.ca by July 24, 2020.

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

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that every alleged, suspected or witness incident of neglect of a resident by the licensee or staff that the licensee knows of, or that was reported to the licensee was immediately investigated and that appropriate action was taken in response to every such incident.

Neglect is defined in the O. Reg. 79/10 as the failure to provide a resident with the treatment, care, series or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety

or well-being of one or more residents.

Inspector #613 reviewed two Complaint reports that were submitted to the Director, identifying concerns regarding the provision of care and safety to the residents and allegations of abuse and neglect.

A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" (RC-20-02-03) last updated June 2020, identified that all reported incidents of abuse and/or neglect would be objectively, thoroughly and promptly investigated, ensuring that reporting requirements to provincial and regulatory bodies had been completed as required, enforcing appropriate consequences for those responsible for abuse or neglect of residents and ensuring that a copy of the documentation and all other evidence collected was stored with in a secure area of the home. The policy further stated that Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. Extendicare had a zero tolerance for abuse and neglect by any person, whether through deliberate acts or negligence would not be tolerated.

A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" (RC-02-01-02) last updated June 2020, identified that the Administrator or delegate was to immediately initiate an investigation of the alleged, suspected or witnessed abuse. All staff were to immediately respond to any form of alleged, potential, suspected or witnessed abuse or neglect.

The Inspector met with the Administrator (ADM) and Assistant Director of Care (ADOC) and requested all written compliant letters that were submitted by staff concerning improper and incompetent treatment or care of residents and allegations of abuse and neglect. They provided the Inspector with four letters dated on specific dates and two that were both dated on the same date. The ADOC also provided four personnel files to the Inspector and stated, "there may be some letters of concerns in these files".

A review of the four written complaint letters that were submitted by staff concerning improper and incompetent treatment or care of residents and

allegations of abuse and neglect identified the following:

A) A letter dated on a specific date, identified resident safety and care concerns for a specific date on a specific shift, alleging improper/incompetent care provided by staff, specifically indicating residents were being transferred without the use of specific equipment or without two staff members, not putting beds into the low position or using falls prevention interventions while residents were in their beds, residents being provided with the wrong diet type and/or texture, residents not receiving peri care during continence product changes and/or not receiving continence product changes and put to bed wet and/or soiled. This letter indicated that RN #117 was notified of the improper and incompetent care and the neglect of resident care on the dates they occurred and that this letter of concern was provided to the Administrator (ADM) on a specific date.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no further documentation to identify that RN #117 had reported the allegations of improper and incompetent care and the neglect of resident care immediately to management, or that the Director had been immediately notified or that an investigation had immediately commenced, and there was no outcome of the investigation or what corrective actions had occurred to prevent recurrence.

B) A letter dated on a specific date, identified allegations of abuse from Dietary Aide (DA) #113 towards resident #007 and identified other resident rights and safety concerns for two dates on a specific shift. This letter alleged that DA #113 had not allowed residents to have coffee during their meal service and were told they could only have it before or after the meal; directing residents to enter the dining room using one door, which was a far distance for residents to ambulate, not allowing them to use the entrance in their hallway and speaking to residents in an inappropriate tone. The written letter indicated on a specific date, resident #007 reported to RPN #107 that DA #113 spoke to them in a tone of voice they had not appreciated, describing the DA's tone of voice as "gruff, coarse and insistent". The letter also indicated concerns of residents being transferred into chairs, toilets and tub and then the resident's being left unattended, which was against the interventions in their care plans.

The Inspector requested the internal investigation file and was provided with the

investigation notes that were started by the Dietary Manager (DM) #100 on a specific date, indicating this incident was not immediately investigated, but rather the investigation commenced three days after the DA became aware of the allegations of abuse. The investigation notes indicated that DM #100 had only spoken to staff and had not spoken to DA #113 or the resident involved. There was no further documentation to identify that the Director had been immediately notified or that DA #113 had been removed from the schedule pending the investigation and there was no outcome of the investigation or what corrective actions that had occurred to prevent recurrence.

C) A letter dated on a specific date, identified resident neglect concerns alleging residents were not having their continence care products changed and were being left in their continence products from two shifts prior, with unused products and cloths from the previous shift found in the resident's bedside table. The letter identified that residents were found soaked in urine to their clothing and that RNs #109 and #110 and RPNs #106 and #107 were aware of the allegations of neglect. The letter was provided to the ADM on a specific date.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no documentation to identify that RN #109, RN #110 or RPN #106 had reported the allegations immediately to management, that the Director had been immediately notified or that an investigation had immediately commenced, and there was no outcome of the investigation or what corrective actions had occurred to prevent recurrence.

D) Another letter dated on a specific date, identified ongoing concerns of resident neglect that had been occurring since April 2020 and that the ongoing concerns of improper and incompetent care and neglect of resident care were reported to various RNs and Management previously. The letter expressed concerns of residents being soaked in urine to their continence care products and clothing or sitting in soiled continent products and wearing the same continent product from the previous two shifts and that the previous shift continence care products and cloths had been found in the resident's bedside tables untouched, residents not having clothing changed and remaining in their night clothes from two shift prior, residents not being repositioned as per their care plans, and allegations that a resident had not been showered for two weeks. This letter identified concerns specifically to the neglect and lack of care

provided by PSW #115 from the prior day shift. The letter was provided to the ADM on a specific date.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no documentation to identify that RN #109, had reported the allegations immediately to management, that the Director had been immediately notified or that an investigation had immediately commenced, and there was no outcome of the investigation or what corrective actions had occurred to prevent recurrence.

A review of PSW #115's personnel file did not have any follow up documentation to verify that the allegations of ongoing concerns of improper and incompetent care and neglect of residents' care had been addressed with corrective action to prevent recurrence.

E) The Inspector reviewed another staff member's personnel file, PSW #116, that was provided by the ADOC. This personnel file contained letters of concern submitted by staff members alleging concerns of resident safety, improper or lack of care, and neglect of resident care by PSW #116, for three different occurrences. A letter dated on two specific dates, indicated concerns regarding resident safety, improper or lack of care, not following resident care plan and neglect of resident care by PSW #116. The letter contained allegation of inappropriate transferring of residents without the use of equipment or the assistance of another staff member, not providing care to residents at a specific time, not changing resident's continence care products in a timely manner and leaving a resident in soiled clothing with stool on their hand and clothing, after a continence care product change. The letter identified that RPN #107 had reported their concerns to RN #110 on a specific date, but had not reported their concerns from one of the dates immediately.

A review of a letter dated on a specific date, signed by RN #110, indicated that RPN #107 had informed them of the multiple concerns regarding resident safety, improper and/or lack of care, not following resident care plans and neglect of resident care by PSW #116 on a specific date. This letter identified that RN #110 sent PSW #116 home immediately after being notified of the care concerns but did not report the allegations immediately to the on-call Manager, rather RN #110 wrote a letter of the concerns and provided it to the Director of Care

(DOC), who received the letter on the following business day.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no documentation to identify that the Director had been immediately notified or that an investigation had immediately commenced, and there was no outcome of the investigation or what corrective actions had occurred to prevent recurrence.

F) Another letter in PSW #116's personnel file, dated on a specific date, identified it was submitted to the Director of Care (DOC) on the same date, by RPN #107, indicating several concerns of resident safety, improper and/or lack of care provided to the residents, not following resident care plans and neglect of resident care provided by a staff member. There was no specific staff member identified, but the care concerns were improper and unsafe transferring, residents being provided the wrong diets, resident's continence care products not being changed, bedtime care or scheduled baths/showers were not being provided, not following individualized resident care plans, residents not being repositioned and infection control issues.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no documentation to identify that the Director had been immediately notified or that the DOC had immediately commenced an investigation, and there was no outcome of the investigation or what corrective actions had occurred to prevent recurrence.

G) Another letter in PSW # 116's personnel file, dated on a specific date, indicated concerns of resident safety, improper and/or lack of care provided to the residents, not following resident's care plans and neglect of resident care on two specific dates, by PSW #116. This letter alleged putting residents to bed then leaving the resident's beds in the high position, moving and transferring a resident post fall without an assessment from a registered staff member, transferring a resident to bed alone that required the use of a equipment, not providing peri care to residents during continence care product changes, providing the wrong type of diet to residents for their snack and other infection control concerns. There were also two letters titled, "Performance Correction Notice" written by RN #117, dated on two specific dates, identifying these letters had been provided to management. The letters identified concerns with PSW

#116, transferring residents without a mechanical lift, not using dietary sheets when providing meals/snacks to the residents, not following resident care plans, not providing peri care during continence care product changes and other infection control issues. There was no documentation to identify if RN #117 had spoken to PSW #116, or the date when RN #117 provided letters to management or to which manager.

The Inspector requested the internal investigation file and the home was unable to provide one. There was no further documentation to identify that the Director had been informed of the improper and incompetent care, that the ADOC immediately commenced an investigation, as DOC was on a LOA, and no outcome of the investigation or what corrective actions had occurred to prevent recurrence.

A review of the Long-Term Care Homes reporting portal did not identify any critical incident reports related to the allegations of improper or incompetent treatment or care or the residents or verbal abuse and neglect of the residents.

During interviews with PSW#101, PSW #105 and RPN#106, they all stated they were aware of resident care, neglect and safety issues occurring on a specific unit. The care staff stated that the concerns have been occurring since March 2020 and were ongoing. The care staff further stated that they had reported their concerns to the registered staff, ADOC or ADM either verbally, via telephone message or in writing via email at the time they had occurred.

During an interview with RN #109 and #110, they both stated they were aware of care issues occurring on the floor, such as residents being left in their continence care products from the previous two shift, residents not being showered, residents being left in their wheelchairs all shift and not being repositioned. Both RNs stated they had not reported the improper or incompetent resident care concerns or the allegations of neglect to management. All staff stated that they were trained on zero tolerance of abuse and neglect annually.

During an interview with the ADOC, they stated that they had not commenced an investigation into the letters of concerns, at the time of the inspection, and still had to speak with staff. The ADOC stated that several RNs did not follow up or

complete an investigation to the care concerns at the time they were brought to their attention and they did not report to management immediately. They further stated they were aware of performance issues by PSW #115 and PSW #116. The ADOC stated they had to set up a meeting to speak with PSW #115 and that PSW #116 had been moved to a different work assignment.

A review of PSW #115 and PSW #116's personnel file did not indicate any recent coaching or discipline had occurred.

During an interview with the ADM, they stated that there was no documentation to support that an investigation or appropriate action had occurred for each reported incident. They further stated they expected an investigation to occur immediately when suspected, alleged or witnessed abuse/neglect occurred. The ADM stated that when they received a written complaint letter from staff involving resident care concerns or safety issues or allegations of abuse or neglect, they forward the letter to the DOC, ADOC or department manager on the same date it was received. The ADM stated they expected the manager to create a folder and commence an investigation immediately and notify the Director when suspected, alleged or witnessed abuse or neglect occurred. The ADM confirmed that staff did not comply with the licensee's zero tolerance of abuse and neglect policy and that no incident had been reported to the Director.

Various care staff members and management were aware of the numerous occurrences of improper and incompetent care and allegations of abuse and neglect that were putting the residents at risk from March 2020 to June 2020, and they did not comply with the procedures of the licensee's policies for zero tolerance of resident abuse and neglect; therefore, the licensee has failed to protect all residents from abuse and neglect by not investigating immediately and taking appropriate action in response to every such incident.

The home had no previous history; however, the severity of the issue was determined to be a level 3 as there was actual risk and harm to the residents. The scope of the issue was a level 2 as the same residents were affected by repeated occurrences.
(613)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

**This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le :** Aug 31, 2020

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**Order(s) of the Inspector**

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

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

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

---

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

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

**Order / Ordre :**

The licensee must be compliant with s. 24 (1) of the LTCHA.

Specifically the licensee must:

(A) Ensure that all Management staff who have reasonable grounds to suspect that improper or incompetent treatment or care to a resident that resulted in harm or risk or harm to the resident or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident that they immediately report the suspicion and information upon which it is based to the Director.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that when improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #613 reviewed two Complaint reports that were submitted to the Director, identifying concerns regarding the provision of care and safety to the

residents and allegations of abuse and neglect.

The Inspector met with the Administrator (ADM) and Assistant Director of Care (ADOC) and requested all written compliant letters that were submitted by staff concerning improper and incompetent treatment or care of residents and allegations of abuse and neglect. They provided the Inspector with four letters dated on specific dates and two that were both dated on the same date. The ADOC also provided four personnel files to the Inspector and stated, "there may be some letters of concerns in these files".

A review of the four letters received identified concerns of resident safety, improper or lack of care, allegations of abuse and neglect of resident care occurring from March to June 2020. See WN #1 for specific details.

A review of the personnel files, identified that there were four additional letters submitted by staff, alleging concerns of resident safety improper or lack of care, verbal and neglect of resident care by PSW #116 and other staff occurring from March to April 2020. See WN #1 for specific details.

A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" (RC-02-01-02) last updated on June 2020, identified that staff must complete an internal incident report and notify their supervisor (or during after-hours the nurse on site). The nurse would then call the Manager on-call immediately upon suspecting or becoming aware of abuse or neglect of a resident. Management would promptly and objectively report all incidents to external regulatory authorities.

A review of the Long-Term Care Homes reporting portal did not identify any critical incident report related to the allegations of improper or incompetent treatment or care or the residents or verbal abuse and neglect of the residents.

During an interview with RN #109 and #110, they both stated they were aware of care issues occurring on the floor, such as residents being left in their continence care products from the previous two shift, not being showered, being left in their wheelchairs all shift and not being repositioned. Both RNs stated they had not reported the neglect allegations or the improper or incompetent care concerns to management. RN #109 stated they did not have time to write

out a report for management and RN #110 stated they thought the care staff was going to report the care concerns to management.

During interview with ADOC, they confirmed that the Director had not been informed immediately for any of the written complaints regarding improper or incompetent treatment or care of a resident or abuse or neglect care concerns.

During an interview with the ADM, they stated the Director had not been notified immediately for any of the written complaints regarding improper or incompetent treatment or care of a resident or abuse or neglect care concerns.

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that when abuse of a resident by anyone or neglect of a resident that resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #613 reviewed two Complaint reports that were submitted to the Director, identifying concerns regarding the provision of care and safety to the residents and allegations of abuse and neglect.

The Inspector met with the Administrator (ADM) and Assistant Director of Care (ADOC) and requested all written compliant letters that were submitted by staff concerning improper and incompetent treatment or care of residents and allegations of abuse and neglect. They provided the Inspector with four letters dated on specific dates and two that were both dated on the same date. The ADOC provided four personnel files to the Inspector and stated, "there may be some letters of concerns in these files".

A review of the written letter of concern dated on a specific date, identified allegations of abuse from Dietary Aide (DA) #113 towards resident #007. The written letter of concern indicated on a specific date, resident #007 reported to RPN #107 that Dietary Aide #113 spoke to them in a tone of voice they had not appreciated, describing the DA's tone of voice as "gruff, coarse and insistent".

Verbal abuse is defined in the O. Reg. 79/10 as any form of communication of a threatening or intimidating nature or any form of verbal communication of a

belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other then a resident.

A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" (RC-02-01-02) last updated on June 2020, identified that management would promptly and objectively report all incidents to external regulatory authorities

A review of the residents' progress notes indicted that resident #007 was upset about the way he was spoken to by DA #113, describing their tone of voice as "gruff, coarse and insistent". The resident requested that a management team member be made aware.

A review of the Long-Term Care Homes reporting portal did not identify any critical incident report related to the allegations of verbal abuse.

During an interview with the Dietary Manager #100, they stated that the way DA #113 had spoken to resident #007 was verbal abuse and confirmed that they had not reported the allegations of verbal abuse to the Director.

During an interview with the Administrator, they confirmed that the allegations of abuse had not been reported to the Director immediately by the Dietary Manager

The home had no previous history; however, the severity of the issue was determined to be a level 3 as there was actual risk and harm to the residents. The scope of the issue was a level 2 as the same residents were affected by repeated occurrences.
(613)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 31, 2020

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**Order(s) of the Inspector**

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

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

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

---

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

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

**Order / Ordre :**

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically the licensee must:

(A) Ensure that all care and management staff are compliant with the licensee's Zero Tolerance of Resident Abuse and Neglect policies and procedures.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect was complied with.

Inspector #613 reviewed two Complaint reports that were submitted to the Director, identifying concerns regarding the provision of care and safety to the residents and allegations of abuse and neglect.

The Inspector met with the Administrator (ADM) and Assistant Director of Care (ADOC) and requested all written compliant letters that were submitted by staff concerning improper and incompetent treatment or care of residents and allegations of abuse and neglect. They provided the Inspector with four letters dated on specific dates and two that were both dated on the same date.

A review of the written letter on a specific date, identified allegations of abuse from Dietary Aide (DA) #113 towards resident #007. The written letter of concern indicated on a specific date, resident #007 reported to RPN #107 that DA #113 spoke to them in a tone of voice they had not appreciated, describing

the DA's tone of voice as "gruff, coarse and insistent".

A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" (RC-02-01-03) last updated June 2020, identified that the Manager would immediately advise the employee that they were being removed from the work schedule, with pay, pending an investigation.

A review of the resident's progress notes indicted that resident #007 was upset about the way he was spoken to by DA #113, describing their tone of voice as "gruff, coarse and insistent". The resident requested that a management team member be made aware.

During an interview with the Dietary Manager #100, they showed the Inspector the DA's work schedule and stated that DA #113 had worked a scheduled shift, following the reported incident on May 31, 2020. The DA confirmed that they had not spoken to the DA or removed them from the from the work schedule after being notified of the allegations of abuse and while pending an investigation.

During an interview with the ADM, they confirmed that DA #113 had not been removed form the work schedule immediately and that they had informed the DA that they were not permitted to return to work until the investigation was completed

The severity of this issue was determined to be a level 3 as there was actual harm and risk to the residents. The home had a level 3 history as they had on-going non-compliance with this section of the LCTHA that included:

-VPC issued February 11, 2019 (2019_638542_0008)
-VPC issued November 18, 2020 (2018_776613_0001)
-VPC issued December 7, 2017 (2017_395613_0020)

(613)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l’inspecteur

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

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Aug 31, 2020

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

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

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

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

**Issued on this 10th day of July, 2020**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Lisa Moore

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