Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée 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
Oct 15, 2020	2020_725522_0004 (A1)	003732-20, 003735-20, 003736-20, 003737-20, 003738-20, 003739-20, 003740-20	Follow up

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 Wonham Street South INGERSOLL ON N5C 3P6

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

Amended by JULIE LAMPMAN (522) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension to the compliance due date for order #001.

Issued on this 15th day of October, 2020 (A1)

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

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

Amended by JULIE LAMPMAN (522) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 30, 31, August 4, 5, 6, 7, and 21, 2020.

The following intakes were inspected during this inspection:

Log # 003732-20 Follow-up to CO#001 from inspection #2019_725522_0018 related to plan of care;

Log # 003735-20 Follow-up to CO#003 from inspection #2019_725522_0018 related to duty to protect;

Log # 003736-20 Follow-up to CO#004 from inspection #2019_725522_0018 related to investigating abuse;

Log # 003737-20 Follow-up to CO#005 from inspection #2019_725522_0018 related to appropriate action taken in response to every incident of abuse;

Log #003738-20 Follow-up to CO#006 from inspection #2019_725522_0018 related to reporting abuse to the Director;

Log # 003739-20 Follow-up to CO#007 from inspection #2019_725522_0018 related locking doors in the home that lead to non-residential areas;

Log # 003740-20 Follow-up to CO#008 from inspection #2019_725522_0018 related to a responsive behaviour plan of care for residents;

Critical Incident System (CIS) report #2628-000015-20/Log #015160-20 related to neglect.

PLEASE NOTE:

A Written Notification (WN), Compliance Order (CO) and Director's Referral related to LTCHA, 2007, c.8, s. 19 (1) identified in concurrent CIS Inspection #2020_725522_0005 (Log# 015575-20) was issued in this report.

A WN and CO related to LTCHA, 2007, c.8, s. 24 (1) identified in concurrent Complaint Inspection #2020_725522_0003 (Log#012700-20, 013158-20, 013561-20, 014915-20) was issued in this report.

A WN related to LTCHA, 2007 S.O. 2007, c.8, s. 101. (3) was issued in this inspection as supporting evidence for Compliance Order #009, Inspection #2019_725522_0018, Compliance Due Date October 31, 2020.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director, Director of Care, Acting Assistant Director of Care, Director of Clinical Services, Registered Nurses, Registered Practical Nurses, an agency Registered Practical Nurse, Personal Support Workers, a Care Support Aide, a Physiotherapist Aide, and a Physician.

Inspector(s) also observed staff to resident interactions, resident to resident interactions, the provision of resident care, observed resident home areas, reviewed resident clinical records, the home's investigative records, training records and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.

- **5 WN(s)**
- **1 VPC(s)**
- **3 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #005	2019_725522_0018	615
O.Reg 79/10 s. 26. (3)	CO #008	2019_725522_0018	615
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2019_725522_0018	615
O.Reg 79/10 s. 9. (1)	CO #007	2019_725522_0018	522

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. 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 witnessed incident of neglect of a resident, that the licensee knew of, or that was reported was immediately investigated.

A Complaint was submitted to the Ministry of Long-Term Care (MLTC) related to neglect of resident #001's continence care.

In an interview, the complainant stated in part, that the resident had been incontinent of bladder and bowel and the complainant had made the staff aware and the staff did not change the resident.

During an interview, Director of Resident Care (DOC) was asked for the home's complaints/concerns for the year 2020. The DOC stated that they had not heard of any complaints in July or June 2020, and provided the home's complaint binder with no documents for the year 2020.

The DOC provided a document of meeting minutes with the resident's family which listed concerns from the family that the resident had not been changed by staff when they were incontinent of bladder and bowel. The minutes indicated the DOC had stated they would follow up with the staff that were working and provide education.

During an interview, the Acting Executive Director (aED) was asked for the documented investigation into the family's concerns. The aED informed the inspector that the DOC had not investigated the incident.

The licensee has failed to ensure that the incident of neglect of resident #001, that was reported to the DOC and aED was immediately investigated.[s. 23. (1) (a)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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 abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A Complaint was submitted to the Ministry of Long-Term Care (MLTC) related to neglect of resident #001's continence care.

In an interview, the Director of Care (DOC) acknowledged that the complainant had reported their concerns to the home.

Review of Long-Term Care Homes.net noted no critical incident report was submitted by the home related to the allegations of neglect of the resident.

In an interview, the Acting Executive Director (aED) stated the incident had not been reported to the Director.

2. A Critical Incident System (CIS) report was submitted by the home to the MLTC related to neglect of resident #009.

A review of the CIS report indicated that an incident of alleged neglect of resident #009 occurred and was reported to the Director the following day. The CIS report described that the Director of Care received an e-mail with concerns that resident #009's care had been neglected by Personal Support Workers (PSWs) the previous two days.

Two days after the first incident a Registered Nurse (RN) sent an email to the Director of Care (DOC) to report the allegation of neglect and asked for guidance on the next step to take.

During an interview, the DOC stated that the RN should have reported the allegations of neglect immediately to the Director.

The licensee failed to ensure that a person who had reasonable grounds to suspect neglect of resident #001 and resident #009 immediately reported the alleged neglect to the Director.

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

Two Complaints were received by the Ministry of Long-Term Care related to concerns of improper care provided to resident #001.

In an interview, the resident's Power of Attorney (POA) stated they had concerns regarding the care the resident had received since their admission to the home.

The complainant stated the resident had a significant weight loss, had declined, was very weak, had several falls and that it had taken two weeks for the resident to receive antibiotics for an infection.

The complainant stated on one occasion they insisted the resident be sent to hospital and the resident was diagnosed with dehydration and an infection. The complainant stated on another occasion they took the resident to hospital themselves where the resident was again diagnosed with an infection.

In an interview, the Acting Executive Director (aED) stated that they had spoken to the complainant who had expressed concerns regarding the resident's care. The aED stated they immediately investigated and implemented a plan and had been working with the resident's family to get the resident back to their previous level of functioning. The aED stated they did not see the concerns as a complaint and they immediately investigated the concerns. The aED stated they did not report the family's concerns regarding improper care to the Director. The aED stated the Director of Care was aware of the concerns and was also responsible to report the concerns regarding improper care to the Director. The aED checked and confirmed that the complainant's concerns regarding improper care had not been reported to the Director.

The licensee has failed to ensure the aED and DOC who had reasonable grounds to suspect that improper or incompetent care of resident #001 that resulted in harm to the resident immediately reported the suspicion and the information upon which it was based to the Director. [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. 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 residents were not neglect by the licensee or staff in the home.

Ontario Regulation 79/10, s. 5. defines neglect as “the failure to provide a resident with the treatment, care, services 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.“

A Complaint was submitted to the Ministry of Long Term Care (MLTC) related to neglect of resident #001’s continence care.

A review of the resident’s clinical records indicated, in part, that the resident had a diagnosis of dementia, bladder and bowel incontinence and was prone to recurrent urinary tract infections (UTI).

In an interview, the complainant stated in part, that the resident had been incontinent of bladder and bowel and the complainant had made the staff aware and the staff did not change the resident.

A review of the resident’s progress notes stated that the resident’s buttocks were reddened.

During an interview, acting Executive Director (aED) acknowledged the incident was neglect.

2. The home submitted a Critical Incident System (CIS) report to the MLTC related to alleged neglect of resident #009.

A review of the CIS report indicated that an incident of alleged neglect of resident #009 occurred and was reported to the Director the following day. The CIS report described that the Director of Care received an e-mail with concerns that resident #009's care had been neglected by Personal Support Workers (PSWs) the previous two days.

A review of the resident's progress notes indicated that the resident had been cleaned, repositioned and their dirty bed stripped as the care had not been provided by the previous shift. An area of altered skin integrity had been reported to the registered staff and a skin assessment had been completed.

During interviews with PSW #117 and PSW #116, they stated they found the resident had not been changed from the previous day, was dirty and had the same clothes on for two days. PSW #116 added that they had noticed the resident had skin breakdown.

During an interview, RN #115 stated that the PSW had reported to her that the resident had been neglected and the RN had reported it to the DOC.

During an interview, the DOC stated it was neglect and they had not completed the investigation.

3. A Critical Incident System (CIS) report was submitted by the home to the MLTC related to an incident involving resident #010.

Review of resident #010's electronic progress notes in Point Click Care (PCC) noted the resident had difficulties earlier in the day and later that day the resident had a fall and had a medical emergency.

In an interview, Agency Registered Practical Nurse (RPN) #104 confirmed they had documented that the resident was observed having difficulties that morning. The RPN stated asked Personal Support Worker (PSW) staff to monitor the resident.

In interviews, PSW #102, PSW #103, and RPN #105 stated they responded to the resident's fall and medical emergency. All three staff acknowledged that First Aid had not been performed to the resident at that time.

In an interview, RPN #106 stated they came to the resident's room to assist and

told staff to get the Director of Care (DOC) as they were the only RN in the building. RPN #106 stated they had brought equipment into the room to assist with the resident's medical emergency and the equipment did not work properly. RPN #106 stated they were directed by the DOC to turn the equipment off and leave the room.

In an interview, RPN #105 stated after the DOC arrived there were no attempts to provide First Aid to the resident.

In an interview, the Acting Assistant Director of Care (aADOC) stated registered staff were to complete audits of the equipment monthly. The aADOC stated the registered staff were new and had not been trained on the audits. The aADOC #107 showed the inspector the equipment audit sheet for 2020, which had not been completed from January to July 2020.

In an interview, the DOC stated they had gone to the resident's room and told the staff to turn off the equipment they were using. When questioned by the inspector, the DOC stated they did not know the resident was having a medical emergency and had not assessed the situation when they entered the resident's room and asked the registered staff what was happening. DOC also stated they did not check the equipment when staff stated it was not working properly. The DOC stated if a resident was in a medical emergency they would expect staff to administer First Aid.

In an interview, with the Acting Executive Director (aED) and the Director of Clinical Services (DCS), the DCS stated the DOC did not debrief with staff after the medical emergency to look at what occurred, what was done well and what could have been done differently.

The licensee has failed to ensure that residents #001, #009 and #010 were protected from neglect. [s. 19. (1)]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the report to the Director included the actions taken in response to the incident, which included the outcome or current status of the individual or individuals who were involved in the incident.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) related to alleged neglect of resident#009.

In the general notes of the CIS report, the home was asked to provide the outcome of the home's investigation and actions planned to prevent recurrence of

neglect and was asked on two separate occasions to include the full name of the staff member who allegedly neglected the resident.

Eight days after the last request, the Director of Care amended the CIS report and indicated audits were completed which did not show any lack of resident care, staff had been interviewed and the investigation had been closed with no findings.

Three days after indicating the investigation was closed the DOC updated the CIS report and indicated after a discussion with inspectors in the home, they were reopening the investigation to ensure all staff were interviewed.

A review of the home's investigation report of this incident had no documented evidence of the investigation.

During an interview with DOC #100, when they were asked why they wrote in the CIS report that staff were interviewed and the investigation had been closed, the DOC stated they were not finished the investigation and still needed to interview all the staff.

During interviews with PSW #116, PSW #117 and RN #115 who were involved in the incident and who reported the allegations of neglect to the DOC, all were asked if the DOC had interviewed them regarding the incident, the three staff members said they had never been spoken to about the incident.

When the inspection was finished and this finding was being written, the investigation was still pending.

The licensee has failed to ensure that the report to the Director included the actions taken in response to the incident, which included the outcome or current status of the individual or individuals who were involved in the incident. [s. 104. (1) 3.]

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 report to the Director includes the actions taken in response to the incident, which includes the outcome or current status of the individual or individuals who were involved in the incident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licensee that the licensee shall comply with every order made under the LTCHA, related to training all staff on reporting of abuse.

On February 27, 2020, during a Critical Incident inspection Compliance Order (CO) #005 was issued with an initial compliance due date of April 6, 2020. The home requested an extension and was granted a compliance due date of May 15, 2020.

CO #005 ordered the licensee to be compliant with s. 23 (1) (b) of LTCHA 2007, related to prevention of abuse and immediate investigation of an alleged abuse.

Specifically, the licensee was to ensure:

a) Documentation and assessment of the resident for distress after an incident of abuse for a minimum of 24 hours, as per the home's Prevention of Abuse and Neglect policy;
b) Complete a documented assessment of the resident for injuries after an incident of abuse;
c) All registered staff receive training and education on the home's Prevention of Abuse and Neglect policy. A written record of attendees must be kept.

The licensee completed part a) and b) of CO #005.
The licensee failed to complete part c) of CO #005.

A review of the home’s training documentation showed a description of the education and training with signatures of staff who attended the training.

During an interview, the Director of Care stated that 30 per cent of staff had not been trained on the home’s Prevention of Abuse and Neglect policy.

The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licensee that the licensee shall comply with every order made under the LTCHA, related to training all staff on reporting of abuse. [s. 101. (3)]

Issued on this 15th day of October, 2020 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JULIE LAMPMAN (522) - (A1)
Inspection No. / No de l'inspection :	2020_725522_0004 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003732-20, 003735-20, 003736-20, 003737-20, 003738-20, 003739-20, 003740-20 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 15, 2020(A1)
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Secord Trails Care Community 263 Wonham Street South, INGERSOLL, ON, N5C-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tammy Smith

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 Vigour Limited Partnership on behalf of Vigour General Partner 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_725522_0018, CO #004;

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 comply with s. 23 (1) (a) of LTCHA 2007.

Specifically, the licensee must ensure:
a)Every alleged, suspected or witnessed incident of neglect of a resident by anyone that the licensee knows of, or that is reported is immediately investigated;
b) All registered staff receive training and education on the home's Prevention of Abuse and Neglect policy. A written record of attendees must be kept.

Grounds / Motifs :

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

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident, that the licensee knew of, or that was reported was immediately investigated.

A Complaint was submitted to the Ministry of Long-Term Care (MLTC) related to neglect of resident #001’s continence care.

In an interview, the complainant stated in part, that the resident had been incontinent of bladder and bowel and the complainant had made the staff aware and the staff did not change the resident.

During an interview, Director of Resident Care (DOC) was asked for the home’s complaints/concerns for the year 2020. The DOC stated that they had not heard of any complaints in July or June 2020, and provided the home’s complaint binder with no documents for the year 2020.

The DOC provided a document of meeting minutes with the resident's family which listed concerns from the family that the resident had not been changed by staff when they were incontinent of bladder and bowel. The minutes indicated the DOC had stated they would follow up with the staff that were working and provide education.

During an interview, the Acting Executive Director (aED) was asked for the documented investigation into the family’s concerns. The aED informed the inspector that the DOC had not investigated the incident.

The licensee has failed to ensure that the incident of neglect of resident #001, that was reported to the DOC and aED was immediately investigated.

The severity of this issue was determined to be a level 2 as there was minimal risk to residents. The scope of the issue was level 1 as it was isolated, involving one out of three residents. The home has a level 5 compliance history as there was a re-issued compliance order (CO) to the same subsection of the LTCHA that included:
• Compliance Order (CO) issued February 27, 2020 (#2019_725522_0018) with a compliance due date of May 15, 2020;
• Compliance Order (CO) issued October 20, 2017, (#2017_607523_0017).
The home also has four or more COs to different subsections of the LTCHA. (615)

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 : Nov 30, 2020(A1)

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)

Linked to Existing Order / Lien vers ordre existant: 2019_725522_0018, CO #006;

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 comply with s. 24 (1) of LTCHA 2007.

Specifically, the licensee must ensure:
a) A person who has reasonable grounds to suspect neglect of a resident, immediately report the suspicion and the information upon which it is based to the Director.
b)All staff receive training and education on mandatory reporting of abuse. A description of the education and training must be documented, along with the signatures off all staff who attended the training.

Grounds / Motifs :

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

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

Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A Complaint was submitted to the Ministry of Long-Term Care (MLTC) related to neglect of resident #001’s continence care.

In an interview, the Director of Care (DOC) acknowledged that the complainant had reported their concerns to the home.

Review of Long-Term Care Homes.net noted no critical incident report was submitted by the home related to the allegations of neglect of the resident.

In an interview, the Acting Executive Director (aED) stated the incident had not been reported to the Director.
(615)

2. A Critical Incident System (CIS) report was submitted by the home to the MLTC related to neglect of resident #009.

A review of the CIS report indicated that an incident of alleged neglect of resident #009 occurred and was reported to the Director the following day. The CIS report described that the Director of Care received an e-mail with concerns that resident #009's care had been neglected by Personal Support Workers (PSWs) the previous two days.

Two days after the first incident a Registered Nurse (RN) sent an email to the Director of Care (DOC) to report the allegation of neglect and asked for guidance on the next step to take.

During an interview, the DOC stated that the RN should have reported the allegations of neglect immediately to the Director.

The licensee failed to ensure that a person who had reasonable grounds to suspect neglect of resident #001 and resident #009 immediately reported the alleged neglect to the Director.
(615)

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

Two Complaints were received by the Ministry of Long-Term Care related to concerns of improper care provided to resident #001.

In an interview, the resident's Power of Attorney (POA) stated they had concerns regarding the care the resident had received since their admission to the home.

The complainant stated the resident had a significant weight loss, had declined, was very weak, had several falls and that it had taken two weeks for the resident to receive antibiotics for an infection.

The complainant stated on one occasion they insisted the resident be sent to hospital and the resident was diagnosed with dehydration and an infection. The complainant

stated on another occasion they took the resident to hospital themselves where the resident was again diagnosed with an infection.

In an interview, the Acting Executive Director (aED) stated that they had spoken to the complainant who had expressed concerns regarding the resident's care. The aED stated they immediately investigated and implemented a plan and had been working with the resident's family to get the resident back to their previous level of functioning. The aED stated they did not see the concerns as a complaint and they immediately investigated the concerns. The aED stated they did not report the family's concerns regarding improper care to the Director. The aED stated the Director of Care was aware of the concerns and was also responsible to report the concerns regarding improper care to the Director. The aED checked and confirmed that the complainant's concerns regarding improper care had not been reported to the Director.

The licensee has failed to ensure the aED and DOC who had reasonable grounds to suspect that improper or incompetent care of resident #001 that resulted in harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

The severity of this issue was determined to be a level 2 as there was minimal risk to residents. The scope of the issue was level 3 as it was widespread, involving three out of three residents. The home has a level 5 compliance history as there was a re-issued compliance order (CO) to the same subsection of the LTCHA that included:
• Written Notification issued June 11, 2020 (#2020_607523_0013).
• Compliance Order (CO) issued February 27, 2020 (#2019_725522_0018) with a compliance due date of May 15, 2020;
• CO issued October 20, 2017 (#2017_607523_0017).
The home also has four or more COs to different subsections of the LTCHA. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 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: 003

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

Linked to Existing Order / Lien vers ordre existant: 2019_725522_0018, CO #003;

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 comply with s. 19 (1) of LTCHA 2007.

Specifically, the licensee must ensure
a) All residents are protected from neglect by anyone, including resident #001 and #009.
b) All registered staff are trained on the use of the home's suction machines;
c) All suction machines in the home will be audited monthly;

Grounds / Motifs :

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

1. The licensee has failed to ensure that residents were not neglect by the licensee or staff in the home.

Ontario Regulation 79/10, s. 5. defines neglect as "the failure to provide a resident with the treatment, care, services 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."

A Complaint was submitted to the Ministry of Long Term Care (MLTC) related to neglect of resident #001's continence care.

A review of the resident's clinical records indicated, in part, that the resident had a diagnosis of dementia, bladder and bowel incontinence and was prone to recurrent urinary tract infections (UTI).

In an interview, the complainant stated in part, that the resident had been incontinent of bladder and bowel and the complainant had made the staff aware and the staff did not change the resident.

A review of the resident's progress notes stated that the resident's buttocks were reddened.

During an interview, acting Executive Director (aED) acknowledged the incident was neglect. (615)

2. The home submitted a Critical Incident System (CIS) report to the MLTC related to alleged neglect of resident #009.

A review of the CIS report indicated that an incident of alleged neglect of resident #009 occurred and was reported to the Director the following day. The CIS report described that the Director of Care received an e-mail with concerns that resident #009's care had been neglected by Personal Support Workers (PSWs) the previous two days.

A review of the resident's progress notes indicated that the resident had been cleaned, repositioned and their dirty bed stripped as the care had not been provided by the previous shift. An area of altered skin integrity had been reported to the registered staff and a skin assessment had been completed.

During interviews with PSW #117 and PSW #116, they stated they found the resident had not been changed from the previous day, was dirty and had the same clothes on for two days. PSW #116 added that they had noticed the resident had skin breakdown.

During an interview, RN #115 stated that the PSW had reported to her that the resident had been neglected and the RN had reported it to the DOC.

During an interview, the DOC stated it was neglect and they had not completed the investigation.
(615)

3. A Critical Incident System (CIS) report was submitted by the home to the MLTC related to an incident involving resident #010.

Review of resident #010's electronic progress notes in Point Click Care (PCC) noted the resident had difficulties earlier in the day and later that day the resident had a fall and had a medical emergency.

In an interview, Agency Registered Practical Nurse (RPN) #104 confirmed they had documented that the resident was observed having difficulties that morning. The RPN stated asked Personal Support Worker (PSW) staff to monitor the resident.

In interviews, PSW #102, PSW #103, and RPN #105 stated they responded to the resident's fall and medical emergency. All three staff acknowledged that First Aid had not been performed to the resident at that time.
In an interview, RPN #106 stated they came to the resident's room to assist and told staff to get the Director of Care (DOC) as they were the only RN in the building. RPN #106 stated they had brought equipment into the room to assist with the resident's medical emergency and the equipment did not work properly. RPN #106 stated they were directed by the DOC to turn the equipment off and leave the room.

In an interview, RPN #105 stated after the DOC arrived there were no attempts to provide First Aid to the resident.

In an interview, the Acting Assistant Director of Care (aADOC) stated registered staff were to complete audits of the equipment monthly. The aADOC stated the registered staff were new and had not been trained on the audits. The aADOC #107 showed the inspector the equipment audit sheet for 2020, which had not been completed from January to July 2020.

In an interview, the DOC stated they had gone to the resident's room and told the staff to turn off the equipment they were using. When questioned by the inspector, the DOC stated they did not know the resident was having a medical emergency and had not assessed the situation when they entered the resident's room and asked the registered staff what was happening. DOC also stated they did not check the equipment when staff stated it was not working properly. The DOC stated if a resident was in a medical emergency they would expect staff to administer First Aid.

In an interview, with the Acting Executive Director (aED) and the Director of Clinical Services (DCS), the DCS stated the DOC did not debrief with staff after the medical emergency to look at what occurred, what was done well and what could have been done differently.

The licensee has failed to ensure that residents #001, #009 and #010 were protected from neglect.

The severity of this issue was determined to be a level 3 as there was actual harm to residents. The scope of the issue was level 3 as it was widespread involving three out of three residents. The home has a level 5 compliance history as there was a re-

issued compliance order (CO) to the same subsection of the LTCHA that included:
• Compliance Order (CO) issued February 27, 2020, (#2019_725522_0018) with a compliance due date of April 6, 2020;
• CO issued August 1, 2018 (#2018_607523_0022);
• CO issued March 26, 2018, (#2018_605213_0004).
The home also has four or more COs to different subsections of the LTCHA. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2020

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

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:

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

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

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

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 15th day of October, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JULIE LAMPMAN (522) - (A1)

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

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