Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: January 17, 2023

Inspection Number: 2022-1252-0002

Inspection Type:
Follow up
Critical Incident System

Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partner

Long Term Care Home and City: Pleasant Meadow Manor, Norwood

Lead Inspector	**Inspector Digital Signature**
Sharon Connell (741721)	Sharon Connell Digitally signed by Sharon Connell Date: 2023.01.30 10:55:10 -05'00'

Additional Inspector(s)
Chantal Lafreniere (194)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 28-30, December 1, 2, 5, 6, 8, 9, 12-16, and 19, 2022.

The following intake(s) were inspected:

- A follow up intake from Inspection #2022_1252_0001, Compliance Order (CO) #001, FLTCA, 2021 s. 28 (1) 2, related to reporting and complaints with a Compliance Due Date (CDD) August 5, 2022.
- A Critical Incident System (CIS) intake related to a fall.
- Two CIS intakes related to abuse.
- A CIS intake related to improper treatment.

The following intake was completed in the Critical Incident Systems inspection:

- A CIS intake related to a fall.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1252-0001 related to FLTCA, 2021, s. 28 (1) inspected by Chantal Lafreniere (194)

The following **Inspection Protocols** were used during this inspection:

Prevention of Abuse and Neglect
Falls Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Food, Nutrition and Hydration

INSPECTION RESULTS

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

The licensee failed to ensure that the home developed and implemented procedures for cleaning and disinfection in accordance with manufacturer's specifications and using, at a minimum, a low-level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices for contact surfaces.

Rationale and Summary
The Housekeeping Equipment and Supplies Policy directed the following:
1. All cleaning chemical/products shall be used and stored in accordance with the manufacturer's instructions.
2. The Environmental Services Manager/Chemical Representation/Designate will ensure employees are trained in the proper use of all chemicals and the quantities that must be applied for each chemical/product to be effective.

The Environmental Services - Infection Prevention and Control (IPAC) Policy was reviewed and lacked detailed instructions for employees to follow in accordance with the manufacturer's recommendations for cleaning and disinfecting solutions.

An environmental services staff confirmed that the home uses a peroxide-based product for cleaning and disinfecting of surfaces for general cleaning. They were unaware of the peroxide disinfectant contact time or whether the wall dispenser concentration was being tested regularly. There were no visible log sheets posted in the housekeeping closet for tracking of chemical testing. The disinfectant manufacturer's product chart was posted on the wall, describing cleaning products and brief directions for their use.

The home's representative from the disinfectant manufacturer confirmed that the concentration of the peroxide disinfectant should be at a minimum of 3500 parts per million (ppm) within 30 seconds and be tested anytime it was dispensed from the wall unit. The representative stated peroxide disinfectant bottles that were not used up during that shift should be tested again prior to use, by the following shift. The manufacturer's reports for a specific period, showed that the concentration test results were within an acceptable range and no corrective actions were required.

The Environmental Services Manager (ESM) confirmed that they were not aware of the manufacturer's instructions to check the disinfectant concentration when dispensing and from shift to shift for refilling bottles.

Failing to ensure that the home developed and implemented procedures for cleaning and disinfection in accordance with manufacturer's specifications and using, at a minimum, a low-level disinfectant for contact surfaces, increased the risk for infection in the home.

Sources: Disinfectant testing observation, policy reviews of Housekeeping Equipment and Supplies Policy and Environmental Services - Infection Prevention and Control Policy, Disinfectant Manufacturer's Regular Service Call reports, and interviews with EMS staff and Manager, and the disinfectant manufacturer's representative. [741721]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 107 (3) 4.

The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health condition.

Rationale and Summary
A critical incident report (CIR) was submitted to report a fall with injury involving a resident. The CIR described that the resident was at a door trying to exit when the door opened, and they attempted to

push past the staff who grabbed the resident causing loss of balance and a fall resulting in injury.

The resident's progress note confirmed that a Registered Nurse (RN) was updated by the hospital that the resident was being referred for appropriate treatment.

As the prior management staff of the home were not available for interview, the inspector was unable to verify the reason for the late reporting.

Failing to ensure that the Director was notified of the fall with injury no later than one business day caused no impact to the resident.

Sources: CIR and the resident's clinical health record. [741721]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee failed to ensure that a resident had a plan of care that set out planned care for the resident.

Rationale and Summary
A resident's clinical health records identified that they were admitted with a specific diagnosis. The plan of care did not have any planned care for the resident related to the specific diagnosis.

A Registered Practical Nurse (RPN) who worked on the unit where the resident resided, stated that they were unaware of the specific diagnosis until asked by the inspector, and the resident's admission progress notes from the previous month did not include the diagnosis as they were not aware.

Another RPN stated that they had been informed a few weeks ago of the resident's specific diagnosis as the IPAC lead had informed them. They confirmed that the IPAC lead had been informing staff informally.

Clinical Care Coordinator (CCC) confirmed that the specific diagnosis or planned care for the resident had not been entered into the plan of care. The resident's admission paperwork from a transferring facility and physical examination had listed the specific diagnosis.

Failing to ensure that the resident's plan of care sets out planned care for a specific diagnosis increased the risk to staff.

Sources: Clinical health records and interviews with RPNs and CCC. [194]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to immediately report a Respiratory Outbreak to the Director.

Rationale and Summary
A CIR was submitted to the Director three days after an outbreak involving a number of residents, was declared by Public Health.

The Public Health Nurse (PHN) was interviewed and verified that the outbreak was declared three days prior to the submission of the CIR to the Director.

The Administrator confirmed the date that Public Health had declared the home in outbreak and stated that the home should have notified the Director immediately.

Sources: CIR, line listing, outbreak debriefing notes, IPAC meeting minutes, and interviews with the Administrator and PHN. [194]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with any standard or protocol.

Rationale and Summary
The IPAC lead confirmed that they were tracking onset dates of residents with symptoms of infection on a line list. Registered staff were to monitor and document in the progress notes every shift for any resident with symptoms of infection, until symptoms resolved. Review of the progress notes for the residents on the line list revealed incomplete documentation of daily symptoms.

An RPN confirmed that they were recently instructed by the Director of Care (DOC) that they were expected to complete once per shift assessment for residents identified with symptoms of infection.

A resident who was placed on isolation for symptoms of an infection, had incomplete shift documentation of symptoms, in the progress notes for a number of days.

Failing to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored may increase the risk of worsening condition for the resident.

Sources: Clinical health record, RPN and IPAC Lead interviews. [194]

WRITTEN NOTIFICATION: NOTIFICATION RE INCIDENTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

The licensee failed to ensure that the resident's substitute decision-maker (SDM) was notified immediately upon the licensee becoming aware of an alleged incident of abuse that upset the resident.

Rationale and Summary
A CIR was submitted to report an allegation of abuse. The CIR described that a Personal Support Worker (PSW) reported to the RN that a resident stated they had been abused.

The clinical health records upon admission confirmed that the resident was cognitively competent.

The home's abuse investigation confirmed that the RN was notified of the incident, and left documentation for the Administrator to review when they returned the following business day.

The staff involved in the incident were not available for interview at the time of the inspection. Review of documentation in the progress notes, indicated that the resident was upset during this time.

The Administrator confirmed that they had contacted the Substitute Decision Maker (SDM) related to the incident of alleged abuse when they became aware of the incident.

Failing to ensure that the resident’s SDM was notified immediately of the reported abuse that caused distress to the resident, did not affect the resident.

Sources: CIR, resident’s clinical health records, internal investigation notes, and Administrator interview. [194]

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee failed to ensure that every alleged incident of abuse was immediately investigated.

Rationale and Summary
A CIR was submitted to report an allegation of abuse involving a resident. The CIR described that a PSW reported to the RN that a resident stated they had been abused

The staff involved in the incident were not available for interview during the inspection. The abuse investigation notes confirmed that the RN interviewed the resident and took the PSW statement, which was left in the Administrator's office, until the next business day. The RN did not immediately notify the Director.

The Administrator confirmed that they received the information for the incident three days after it had occurred and initiated the investigation. The Administrator confirmed that the RN should have notified the on-call manager.

Failing to ensure that the reported abuse was immediately investigated, posed a risk to the residents.

Sources: CIR, abuse investigation notes, resident clinical health records, and Administrator interview. [194]

COMPLIANCE ORDER CO #001 FOOD PRODUCTION

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (7) (a)

The Inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Provide education to all kitchen staff, related to the testing of the chemical concentration for the dishwasher sanitizer, along with materials (test strips) required for the testing. Keep a documented record of the education provided and who attended.
2. Post procedures for the testing of the chemical concentration for the dishwasher sanitizer, near the dishwasher and easily accessible to all kitchen staff.

3. Test the chemical concentration for the dishwasher sanitizer, three times daily after breakfast, lunch, and supper meals.
4. Record test results including who completed the test, the date, time, test strip results in parts per million (ppm), and any corrective actions taken for results below the minimum required ppm concentration.
5. Complete weekly audits by the Kitchen Manager of the chemical concentration for the dishwasher sanitizer, for a period of two months.
6. Complete a Kitchen Manager and Administrator review of the disinfectant manufacturer's monthly reports for a specific period, and address and document any areas of concern.
7. Update the home's policy to include the process where the Kitchen Manager and Administrator review the disinfectant manufacturer's reports monthly, and weekly audits of the chemical testing by the Kitchen Manager. Keeping a record of any corrective actions taken.

Grounds
The licensee failed to ensure that the staff of the home complied with their Dish Machine Temperature and Chemical Concentration Logging policy, for the safe operation and cleaning of equipment related to the food production system and dining and snack service.

Staff failed to consistently use the appropriate test strip required for testing the concentration of the dishwasher sanitizer and lacked knowledge of the minimum acceptable concentrations directed by the manufacturer.

Testing of the dishwasher sanitizer was performed and showed unacceptable results.

The Dish Machine Temperature and Chemical Concentration Logging policy, directed that the chemical concentration was to be tested and documented regularly. The policy directed that when problems were identified with the equipment it was to be immediately discontinued and managers notified.

A disinfectant manufacturer's service report noted the following concern and corrective action: "Sanitizer was at zero, I've primed and trained staff on how to and when to check the titration". Documentation in the following service report indicated that the "Sanitizer was at zero when I arrived. The pickup line was not in the jug properly. This has been adjusted and it is right where it needs to be".

The disinfectant manufacturer's representative confirmed the concentration levels for the dishwasher sanitizer was below acceptable levels for a number of visits.

The Kitchen Manager confirmed that part of the process for the dish room chemical checks was to have staff check that the line connecting the sanitizer jug to the dishwasher was in place and testing of the sanitizer concentration was conducted after meals.

The staff confirmed that the scheduled chemical tests for the dishwasher sanitizer had not been done for a period of time.

After chemical concentration tests read below acceptable levels, the Kitchen Manager remarked that they would continue to use the dishwasher until it could be fixed.

The Administrator confirmed that the Kitchen Manager should have discontinued use of the dishwasher immediately and initiated a three-sink ware washing system.

Failing to ensure that the home and that the staff of the home comply with policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service, increased the risk of infection at the home.

Sources: Observation of sanitizer testing, policy review of Dish Machine Temperature and Chemical Concentration Logging policy, disinfectant manufacturer's monthly service reports and Low Temperature Dishwasher Audit and Chemical Check Audit Log Sheet and interviews with kitchen staff, Administrator, Kitchen Manager, and the disinfectant manufacturer's representative. [741721]

This order must be complied with by
March 17, 2023

COMPLIANCE ORDER CO #002 BED RAILS

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:

1. Keep a documented record, of the completed bed system evaluation for all residents who are provided with any changes to their existing bed system.
2. Develop a tracking system to record/document all completed bed system evaluation for residents who:
    - have failed the bed system evaluation, noting any corrective action,
    - have required any changes to their existing bed system (mattress, bed rails or bed frame)
    - are new admissions to the home.

Grounds
The licensee failed to ensure that where bed rails were used, the resident was assessed and the resident's bed system was evaluated in accordance with evidence-based or prevailing practices, to minimize the risk to the resident.

A CIR described an incident of entrapment involving a resident. The resident was found on the floor with an appendage stuck in the bedrails. The Fire Department was called for assistance to remove the bed rail and dislodge the resident. The resident experienced injury and had no recall of the incident.

The DOC confirmed that a bed system evaluation had not been completed after the old bed system (bedframe) malfunctioned and was changed out.

Failing to ensure that the residents bed system was evaluated to prevent entrapment, placed the resident at significant risk.

Sources: CIR, internal investigation notes, resident's clinical health record and DOC interview. (DOC) [194]

This order must be complied with by
March 17, 2023

COMPLIANCE ORDER CO #003 PLAN OF CARE

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:

1. For all new admissions to the home, the plans of care will be reviewed with direct care staff on every shift for 72 hours post admission, for a period of two months. Specifically, care areas related to responsive behaviours, ambulation and use of mobility aides will be communicated, when applicable.
2. Keep a documented record for all shifts, of the reviews provided, for a period of two months. The documented record will include the name of the resident, name of the staff including designation and the resident information provided.

Grounds
The licensee has failed to ensure that a resident's care related to responsive behaviours and mobility, as set out in the plan of care, was provided as specified in the plan.

A Critical Incident Report (CIR) described a fall involving a resident. The resident was noted to have an unsteady gait and non-compliance with using their mobility assisting device. At the time of the incident a staff member tried to prevent the resident from exiting the home resulting in a loss of balance and a fall. A post fall assessment identified an injury. The resident was transferred for further assessment after a number of days with ongoing pain.

The resident's plan of care identified strategies related to responsive behaviours and mobility.

The post fall assessment indicated that several factors contributed to the fall.

The DOC stated staff were expected to call for assistance to redirect residents when appropriate.

A staff member confirmed that shortly before the fall they had assisted the resident with personal care, returning them to a common area. The staff confirmed they did not remember that the resident used a mobility assistive device.

Failing to ensure that the care set out in the plan of care related to use of a mobility assistive device, and gentle redirection for exit seeking, contributed to the resident fall, resulting in injury.

Sources: Clinical record review, admission care plan, post fall investigation, progress notes, DOC and staff interviews. [741721]

This order must be complied with by
March 17, 2023

COMPLIANCE ORDER CO #004 INFECTION PREVENTION AND CONTROL PROGRAM

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:

1. Complete daily audits of the visitors screening log for a period of four weeks, to ensure that the screening measures are being complied with.
2. Keep a documented record of the completed audits for a period of four weeks, noting any corrective actions taken.

Grounds
The licensee failed to ensure staff participated in the implementation of the IPAC program related to the screening of visitors for COVID-19.

The Entrance screening policy, directed that, active self-screening prior to entry would be required for all employees, essential caregivers, visitors, and any other person's entering the home via use of e-Pass and Rapid Antigen Test (RAT) self-swabbing. Any incidence of failed screening would be immediately reported to the Administrator or designate.

A visitor was observed entering the home without completing the COVID-19 screening. The IPAC lead confirmed that the visitor had not completed the COVID-19 screening prior to entering the home, and they assisted the visitor when they went to speak to them. Daily audits of the visitors' logs were not being completed.

Failing to ensure that visitors were screened for COVID-19 prior to entering the home, placed the home at increased risk of infection.

Sources: Observation of the visitor entering the home, review of the visitors' log, home's Entrance Screening policy, and interview with IPAC Lead. [194]

This order must be complied with by
March 17, 2023

COMPLIANCE ORDER CO #005 INFECTION PREVENTION AND CONTROL PROGRAM

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Develop an audit method, to track alcohol-based hand rub (ABHR) expiry dates and initiate a process that ensures that all ABHR are removed when they have expired.
2. Complete monthly audits for a period of two months, to check the ABHR for expiration.
3. Keep a documented record of the audits, for a period of two months, including who it was completed by.

Grounds #1
The licensee failed to ensure that the hand hygiene program as per IPAC Standard 10.1 included access to hand hygiene agents, including 70-90% ABHR at both point-of care and in other resident and common areas, and any staff that provides direct resident care has immediate access to 70-90% ABHR.

Expired ABHR pump bottles were observed in the dining room and management offices.

A staff member confirmed that the ABHR was expired and informed the Kitchen Manager who immediately retrieved a new case of ABHR pump bottles to replace the expired product.

Failing to ensure that ABHR available to staff and residents in the dining area was maintained at 70-90% alcohol content, increased infection transmission risk in the home.

Sources: Dining room observations, staff and Kitchen Manager interviews. [741721]

Grounds #2
The licensee failed to ensure that IPAC Standard 9.1 (d) requiring at a minimum, that Additional Precautions include appropriate selection, and application of personal protective equipment (PPE) was followed, when a visitor was observed to be lacking eye protection while visiting in a droplet contact isolation room.

A resident who was isolated, was observed sitting in their room with a visitor. The visitor was wearing a gown and N95 mask, but the goggles were not applied.

The DOC verified that the resident had a visitor who had previously received education, and there was signage posted on the resident's door, providing instructions for putting on and taking off PPE.

The clinical health record confirmed that the resident was symptomatic and in isolation.

Failing to ensure that visitors at the home apply appropriate PPE when entering additional precaution rooms, placed the home at risk of spreading infections.

Sources: Visitor observation, and DOC interview. [194]
This order must be complied with by
March 17, 2023

COMPLIANCE ORDER CO #006 BINDING ON LICENSEE

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Ensure that all general visitors have been tested for COVID-19 with a negative result prior to entering the home.
2. Ensure that the Visitors Log records are audited daily by the IPAC lead, for a period of four weeks, ensuring that the COVID-19 testing process at the home is being carried out as indicated.
3. Keep a documented record of the audits completed, for a period of four weeks, noting any corrective actions taken.

Grounds
The licensee failed to comply with every operational or policy directive that applies to the long-term care home. The Guidance document directed that all general visitors, receive and demonstrate a negative result from an antigen test taken at the long-term care home on that day.

A visitor was observed entering the home without completing the COVID-19 testing. The IPAC lead confirmed that the visitor had not completed the COVID-19 testing prior to entering the home, and they assisted the visitor when they went to speak to them. Daily audits of the visitors' logs were not being completed.

Failing to ensure that visitors were tested with an antigen test prior to entering the home, placed the home at increased risk of infection.

Sources: Observation of the visitor entering the home, visitors' log, COVID-19 guidance document for Long-term Care Homes in Ontario, October 14, 2022, IPAC Lead interview. [194]

This order must be complied with by
March 17, 2023

COMPLIANCE ORDER CO #007 POLICY TO PROMOTE ZERO TOLERANCE

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Review emotional and physical abuse definitions with the specific RNs and PSW identified in the incident.
2. Review the home's abuse policy with identified RNs specifically, reporting to management and steps to be taken when staff are identified in a reported abuse incident
3. Review the home's abuse policy with identified RNs specifically related to action and assessments required of the identified residents involved in any abuse incident.
4. Conduct audits of reported incidents of abuse for a period of two months, to ensure that the licensee's abuse policy is being complied with.
5. Keep a documented record of all audits completed for a period of two months, noting any corrective actions taken.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home’s policy Zero Tolerance of Abuse policy directed:

- that in the event of an allegation or complaint of abuse or neglect a resident, the charge nurse in consultation with the manager on call shall assess the risk and severity of the incident and determine the need to relieve the accused persons of their duties pending investigation.
- In cases where a staff member witnesses/suspects/hears about an act of abuse or neglect, the first course of action shall be to ensure that the resident is taken to a safe and secure environment. Once the resident is physically safe, the following steps shall be taken,
- Report incident to direct manager, Director of Care or Administrator
- Provide the resident with one-on-one supportive measures
- Assess needs for advanced medical assessment and treatment including psychosocial or physical intervention.

Grounds #1
A CIR detailed an allegation of abuse involving a resident. A PSW reported to the RN that a resident stated they had been abused.

The internal abuse investigation confirmed that the RN did not notify the on-call manager, DOC or Administrator when notified of abuse by the PSW. The clinical health records confirmed that there was no assessment completed for the resident. The progress notes confirmed that the resident was upset by the incident.

The Administrator confirmed that the RN should have notified the on-call manager when they received the resident's allegation of abuse.

Failing to ensure that the home's Zero Tolerance of Abuse policy is complied with, increased the risk of ongoing abuse at the home.

Source: CIR, Zero Tolerance of Abuse policy, abuse investigation notes, clinical health records and Administrator interview. [194]

Grounds #2
A CIR detailed an allegation of abuse involving a resident. An RPN reported to an RN that a resident was upset about the way a PSW had spoken to them.

The home determined from their investigation that the allegations of abuse involving the resident were founded. The RN did not notify the on-call manager at the time of the incident, resulting in late reporting. The RN did not consult with the management at the home to determine the need to relieve staff from duty.

The RN confirmed that they had not immediately notified the on-call manager when the allegations of abuse were reported.

The Administrator confirmed that the RN should have reported the resident's allegation of abuse to the on-call manager.

Failing to ensure that the home's Zero Tolerance of Abuse policy is complied with, increased the risk of ongoing abuse at the home.

Sources: CIR, Zero Tolerance of Abuse policy, abuse investigation notes, clinical health record, and staff and Administrator interviews. [194]

This order must be complied with by
March 17, 2023

COMPLIANCE ORDER CO #008 PREVENTION OF ABUSE AND NEGLECT

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must

1. Review emotional and physical abuse definitions with the specific RNs and PSW identified in the incident.
2. Review the home's abuse policy with the specific RNs, related to their roles for reporting abuse incidents in the home. Keep a documented record of the education provided.
3. Conduct audits of reported incidents of abuse for a period of two months, to ensure that the licensee's abuse policy is being complied with.

The Licensee failed to ensure that a person who has reasonable grounds to suspect that abuse has occurred shall immediately report the suspicion and the information upon which it is based to the Director.

"Abuse" - definition
O. Reg. 246/22 s. 2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2),
(a) the use of physical force by anyone other than a resident that causes physical injury or pain.
"emotional abuse" means,
(a) any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Grounds #1
A CIR reporting an allegation of abuse involving a resident was not immediately reported to the Director. The investigation notes confirmed that an RN was informed by a PSW, that a resident reported abuse.

The staff named in the incident were not available for interview at the time of the inspection.

The Administrator confirmed that the RN should have reported the incident to the on-call manager so that the Director could be notified. The Administrator reported the abuse incident several days later.

The home's Zero Tolerance of Abuse policy, directed:

- that in the event a Critical incident occurs after hours or on the weekend, the on-call manager shall be notified immediately by telephone of the incident.
- the Administrator of designate shall contact the Director of Operations and the Ministry of Long-Term Care as per the above policy to report each Critical Incident.

Failing to ensure that any person who has reasonable grounds to suspect that abuse has occurred shall immediately report he suspicion and the information to the Director, increases the potential risk of abuse at the home.

Sources: CIR, abuse investigation notes, clinical health record, and Administrator interview. [194]

Grounds #2
A CIR reporting abuse involving a resident was not immediately reported to the Director. The investigation notes confirmed that the RPN reported an allegation of abuse to the RN when the resident reported that they were upset about the way a PSW spoke to them.

The RN's documentation confirmed that the resident was upset about the incident. They also documented that they had spoken with staff on duty about respecting residents' rights to choose and to be aware that tone of voice can be intimidating to residents.

The home's internal investigation determined that the allegations of abuse were founded.

The home's Zero Tolerance of Abuse policy, directed:

- that in the event a Critical incident occurs after hours or on the weekend, the on-call manager shall be notified immediately by telephone of the incident.
- the Administrator or designate shall contact the Director of Operations and the Ministry of Long-Term Care as per the above policy to report each Critical Incident.

The Administrator notified the Director of the incident of abuse the following day, when it was reported to them.

Failing to ensure that a person who has reasonable grounds to suspect that abuse has occurred shall immediately report the suspicion and the information upon which it is based to the Director, increased the risk of ongoing abuse at the home.

Source: CIR, abuse investigation notes, Zero Tolerance of Abuse policy, clinical health record and staff and Administrator interviews. [194]

This order must be complied with by
March 17, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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