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

Central East Service Area Office
33 King Street West, 4th Floor
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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 13, 2021	2021_718535_0015 (A1)	009148-21, 010197-21, 010779-21, 010880-21, 012177-21, 012948-21	Complaint

Licensee/Titulaire de permis

Unionville Home Society
4300 Highway #7 Markham ON L3R 1L8

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

Union Villa
4300 Highway #7 Unionville ON L3R 1L8

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

Amended by MOSES NEELAM (762) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This licensee inspection report has been revised to reflect the new Compliance Due Date as October 29, 2021 from October 15, 2021, and the requirement to submit a plan to October 22, 2021 from October 8, 2021. The Complaint inspection, Report #2021_718535_0015 was completed on August 19, 2021.

A copy of the revised report is attached

Issued on this 13th day of October, 2021 (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

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

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

Amended by MOSES NEELAM (762) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 11, 12, 13, 16, 17, 18, 19, 2021.

The following intakes were completed during this Inspection:

Log #009148-21 was related to compliance order #001 from inspection #2021_882760_0017 regarding s. 229 (4), with compliance due date June 14, 2021;

Log #010197-21 was related to falls,

Log #010779-21 was related to infection prevention and control program,

Log #010880-21 was related to responsive behavior,

Log #012177-21 was related to accommodation services and food quality,

Log #012948-21 was related improper care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Quality Educator and IPAC Lead, Environmental Service Manager, Food Services Manager, Social Services Worker (SSW), Environmental Service Supervisor, Physiotherapist (PT), Housekeeping staff, registered staff (RN/RPN), personal support workers (PSWs), PSW Student, substitute decision-makers (SDM) and residents.

During the course of the inspection, the inspector conducted observations on all resident care areas, observed resident to resident and staff to resident interactions, reviewed clinical health records, staff schedules, internal investigation records and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Falls Prevention
Food Quality
Infection Prevention and Control
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home

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

- **10 WN(s)**
- **7 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure staff participate in the implementation of the infection prevention and control program.

The Ministry of Long-Term Care (MLTC) received a complaint stating concerns that residents' hands were not being cleaned before and after meals.

On two identified dates, the Inspector observed the lunch meal in the dining room of a home area and noted that staff did not consistently perform hand hygiene for residents before and after the meals on both days.

On another identified date, the Inspector interviewed three residents on three separate resident home areas related to staff performing hand hygiene before and after meals. All residents interviewed responded that it was left up to them to remember to clean their hands before and after meals and acknowledged that they did not observe staff consistently performing hand hygiene for residents before and after meals.

The inspector also noted that some screeners at the main entrance of the home did not actively screen visitors and staff by asking the required screening questions on two identified dates. The Inspector observed the same and informed the DOC prior to these dates; however, some screening staff continued to passively screen staff by allowing them to walk pass screening without asking the screening questions and visitors by providing the paper questionnaire to be complete and return to them, without actively screening.

The home was issued a compliance order related to the same section of the legislation s. 229 (4). The compliance order was followed up during this inspection, however s. 229 (4) will be re-issued because of the above findings.

Sources: Inspector observations, documented complaint, resident interviews, compliance order #001, s. 229 (4).

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. 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 the resident was protected from neglect.

For the purposes of the Act and s. 5 of the Ontario Regulation 79/10, neglect means 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.

The MLTC received a compliant regard improper care of a resident. On an identified date, the PSW informed the RPN that the resident was experiencing pain and discomfort while providing care. The RPN conducted all applicable assessments, informed the resident's family and called the physician. They were not informed by the second RPN who had worked the previous shift that the resident had experienced pain and swelling on their shift.

During two separate interviews, the second RPN provided false information and denied awareness regarding the resident's injury, which misguided the

interdisciplinary team, the home's investigation of the incident and prolonged the resident's discomfort. The inspector reviewed the home's video footage of the resident's interactions with staff the day the injury was discovered. It was noted that the second RPN assessed the resident during their shift and provided them with pain medication which was not signed for in the medication administration records.

The primary PSW verified that they provided personal care for the resident and they had informed the second RPN that resident appeared to have an injury, then brought the resident to the nursing station to be examined by the RPN.
The resident's SDM was onsite and also confirmed that they heard the resident express discomfort when the second RPN was providing care to the resident, however the nurse did not acknowledge the resident's discomfort.

The second RPN did not document their assessment of the resident, did not follow up related to their injury, did not report the injury to the physician; did not document the administration of medication, did not conduct a pain assessment, nor notify the resident's SDM that they had a possible injury.
On a later date, the resident was sent to hospital related to their ongoing pain, and they were diagnosed with a injury.

The DOC completed an investigation; however the investigation was unfounded since they were provided false information by the second RPN and they were unaware of the evidence shown in the video footage until it was discovered during the inspection. The DOC reported that the registered staff resigned from the home, and the incident was reported to the ministry and to the College of Nurses of Ontario since the RPN's inaction or pattern of inaction jeopardized the health, safety or well-being of the resident.

Sources: Home's investigation notes, emergency department record, resident's progress notes, EMAR, interviews with RPN, PSW and the DOC.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the resident was afforded privacy in treatment and in caring for their personal needs.

The resident's SDM expressed concerns that the resident refused to be showered by staff in the home unless their SDM was present. The SDM stated that the resident's behavior could be related to a lack of trust and privacy while being showered by the staff. The resident's written care plan indicated that their SDM should be present during the shower.

On an identified date and time, the Inspector observed the PSW providing a shower to a resident in the spa room; and noted the door was held open by another PSW while conversating with the PSW providing the shower to the resident. The Inspector observed that there was a breach in privacy and verified that same with both PSWs.

Sources: Inspector's observation, SDM statement, resident's written care plan, interviews with both PSWs.

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 the resident was afforded privacy in treatment and in caring for their personal needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident was being reassessed and the plan of care revised because the care set out in the plan had not been effective, different approaches had been considered.

The resident was assessed by the home and was noted to display a responsive behavior. On an identified date, the Inspector observed the resident actively engaging in the behavior. Their written care plan included interventions to support the resident's safety while engaged in the behavior, however, there was no intervention to prevent the behavior, which was upsetting to other residents who resided in that home area.

During the interview, the PSW verified the resident's responsive behavior, and stated that nothing could be done except to redirect them and ensure their safety. The home's Director of Care (DOC) verified that the resident should be prevented from performing the behavior when possible and other interventions should be discussed and implement to prevent the behavior when possible. Therefore, the resident's plan of care was not effective and different approaches should be considered.

Source: Resident's written care plan, interview with the resident, SDM and the DOC.

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 when the resident is being reassessed and the plan of care is revised since the care set out in the plan was not effective that different approaches are considered, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's right to live in a safe and clean environment.

On two identified dates, the Inspector observed that two resident home areas, there were multiple resident rooms showing evidence of uncleaned malodorous carpets.

During an interview, the home's Environmental Service Supervisor (ESS) acknowledged the uncleaned carpets in the identified rooms and verified that they did not have a record of when the carpets were last cleaned. The ESS further stated that housekeeping staff do not sign on a document when they finish cleaning their assigned work area. A new checklist was developed and implemented to ensure housekeeping staff accountability.

Therefore, two of the five resident home areas were observed to have stained, malodorous and uncleaned carpets in multiple resident rooms.

Sources: Inspector's observations and interviews with ESS.

2. The licensee has failed to ensure that the home was maintained in a safe condition and in a good state of repair.

The MLTC received a complaint regarding wall disrepair in the home. On two

identified dates, the Inspector observed that two resident's home areas had evidence of wall disrepair beside or behind residents' beds.

During an interview, the home's Environmental Service Supervisor (ESS) and Environment Service Manager (ESM) acknowledged the areas of disrepair by conducting a room by room audit, and scheduling the home's Painter and Maintenance Technician to repair identified despair areas on the walls in resident rooms and in the common areas of the home.

Therefore, two of the five resident home areas were observed to be in a state of disrepair to the walls in identified resident's rooms.

Sources : Inspector's observations and interviews with ESS and ESM.

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 the resident's right to live in a safe and clean environment; and ensure that the home is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the temperature was measured and documented at least once every morning, once every afternoon between 12 p.m. and once every evening or night.

A review of the home's Indoor Temperature and Humidity Logs indicated that the home measured and documented the temperature only once daily between the hours of 1230 hours and 1400 hours.

The home's Environmental Service Supervisor (ESS) confirmed that the temperature is documented once daily, and not three times daily as required by the Regulation.

Sources : Indoor Temperature and Humidity Logs, interview with ESS and the ESM.

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 the temperature are measured and documented at least once every morning, once every afternoon between 12 p.m. and once every evening or night, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure staff used safe transferring and positioning techniques when assisting residents.

A review of the resident's plan of care indicated they used a mechanical lift for transferring and required two plus staff to assist with transferring the resident. The home policy indicated that two trained staff were to operate mechanical lift and/or sit-to-stand together at all times.

During separate interviews, the PSW and PSW Student confirmed that they have been transferring the resident together without the support of another trained staff. During an interview, the DOC verified that the home requires two trained staff to transfer the resident when using a mechanical lift.

Sources: Home's Minimal Lift Program policy, resident's written care plan and interviews with the PSW, PSW student and DOC.

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received a pain assessment using a clinically appropriate assessment instrument specifically designed to assess pain.

On an identified date, the resident's progress notes and staff interviews indicated that the resident experienced ongoing pain in a specific body part and later they received a diagnosis related to what would be an injury of unknown cause.

The resident was administered pain medication over a period of two weeks, but pain assessment were only completed at the beginning and end of the observation period despite their ongoing pain. The home's pain management policy indicated a pain assessment utilizing a clinically appropriate instrument was to be completed when a resident exhibits a change in health status or pain was not relieved by initial intervention and when taking pain-related medication for greater than 72 hours.

The RPN verified that the resident should have received more frequent pain assessments as per the home's policy.

Sources: The home's pain management policy, resident' EMAR, diagnostic test result, interview with the RPN.

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 when a resident is experiencing pain, they area assessed using a clinically appropriate assessment instrument specifically designed to assess pain, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint concerning the care of a resident was investigated, resolved where possible, and responded to within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to the resident, investigated immediately.

The MLTC received a complaint related to the home's compliant process. The resident's SDMs stated that they left voice-mail messages for the DOC related to concerns regarding the resident's diagnosed injury of unknown cause, however they did not receive a response within an appropriate timeline.

A review of the home compliant binder revealed that the SDM complaint was not recorded on the log. During an interview, the DOC explained that they did not receive the message until they returned from vacation, and that they conducted an investigation related to the incident and reported back to the family, however the outcome was beyond the required timeline.

Sources : Home's complaint binder, email complaint from the SDM, and interview with the DOC.

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 every written or verbal complaint concerning the care of a resident was investigated, resolved where possible, and responded to within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to the resident, investigated immediately, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure any written complaint received by the home concerning the care of a resident was forwarded to the Director.

The resident's SDM shared the written complaint with the inspector by email for review. The home's DOC acknowledged the receipt of the email from the resident's SDM, and verified that the email was considered to be a written complaint, however the written complaint was not forwarded to the Director.

Sources: Written complaint from the SDM, interview with SDM and DOC.

Issued on this 13th day of October, 2021 (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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MOSES NEELAM (762) - (A1)
Inspection No. / No de l'inspection :	2021_718535_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009148-21, 010197-21, 010779-21, 010880-21, 012177-21, 012948-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 13, 2021(A1)
Licensee / Titulaire de permis :	Unionville Home Society 4300 Highway #7, Markham, ON, L3R-1L8
LTC Home / Foyer de SLD :	Union Villa 4300 Highway #7, Unionville, ON, L3R-1L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Terry Collins

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 Unionville Home Society, 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: 2021_882760_0017, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

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

(A1)
The licensee must be compliant with s. 229 (4) of the O. Reg. 79/10.

Specifically, the licensee shall prepare, submit and implement a compliance plan
outlining how the licensee will ensure that all staff participate in the implementation of the IPAC Program.

The compliance plan shall include but is not limited to the following:

1. Develop and implement measures to ensure staff offer to clean residents' hands before and after meals.

2. Develop and implement measures to ensure all entrance screeners actively screen staff, including management and visitors prior to entering the long-term care home.

3. Keep a record of all actions undertaken and completed for the above items; and include the name of the most responsible person and a timeline for achieving compliance, for each objective/goal listed in the plan.

Please submit the written plan for achieving compliance to the LTC Home Inspector: Moses Neelam, MLTC, by October 22, 2021, via email to: CentralEastSAO.moh@ontario.ca. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. Compliance Order (CO) #001 from inspection #2021_882760_0017 served on June 4, 2021, with a compliance date of June 14, 2021, is being re-issued as follows:

The licensee has failed to ensure staff participate in the implementation of the infection prevention and control program.

The Ministry of Long-Term Care (MLTC) received a complaint stating concerns that residents' hands were not being cleaned before and after meals.

On two identified dates, the Inspector observed the lunch meal in the dining room of a home area and noted that staff did not consistently perform hand hygiene for residents before and after the meals on both days.

On another identified date, the Inspector interviewed three residents on three separate resident home areas related to staff performing hand hygiene before and after meals. All residents interviewed responded that it was left up to them to remember to clean their hands before and after meals and acknowledged that they did not observe staff consistently performing hand hygiene for residents before and after meals.

The inspector also noted that some screeners at the main entrance of the home did not actively screen visitors and staff by asking the required screening questions on two identified dates. The Inspector observed the same and informed the DOC prior to these dates; however, some screening staff continued to passively screen staff by allowing them to walk pass screening without asking the screening questions and visitors by providing the paper questionnaire to be complete and return to them, without actively screening.

The home was issued a compliance order related to the same section of the legislation s. 229 (4). The compliance order was followed up during this inspection, however s. 229 (4) will be re-issued because of the above findings.

Sources: Inspector observations, documented complaint, resident interviews, compliance order #001, s. 229 (4).

An order was made by taking the following factors into account:

Severity: There was minimal harm or risk to residents at this time since the home was not currently in an outbreak.

Scope: The scope of this non-compliance was widespread since screening at the entrance affects all residents and staff in the long-term care home; and three residents were interviewed from three different home areas regarding hand hygiene practice.

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

Compliance History: The licensee continues to be in non-compliance with s. 229 (4) of the O. Reg. 79/10, resulting in the compliance order (CO) being reissued. CO #001 was issued on June 4, 2021 (Inspection #2021_882760_0017) with a compliance due date of June 14, 2021. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 29, 2021(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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act
(LTCHA), 2007.

Specifically, the licensee shall prepare, submit and implement a compliance plan
outlining how the licensee will ensure that residents are protected from neglected by the licensee or staff.

The compliance plan shall include but is not limited to the following:

1. Measures to ensure registered staff report residents' injuries, document their assessments/ actions taken and complete the appropriate referral to members of the interdisciplinary team.

2. Measures to ensure timely investigation of all suspected or alleged incidents of neglect, and report the outcome to the resident's substitute decision-maker.

3. Measures to ensure all suspected or alleged cases of neglect are immediately reported to the Director.

4. Keep a record of all actions undertaken and completed for the above items; and include the name of the most responsible person and a timeline for achieving compliance, for each objective/goal listed in the plan.

Please submit the written plan for achieving compliance to the LTC Home Inspector: Veron Ash, MLTC, by October 15, 2021, via email to: CentralEastSAO.moh@ontario.ca. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure the resident was protected from neglect.

For the purposes of the Act and s. 5 of the Ontario Regulation 79/10, neglect means 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.

The MLTC received a compliant regard improper care of a resident. On an identified date, the PSW informed the RPN that the resident was experiencing pain and discomfort while providing care. The RPN conducted all applicable assessments, informed the resident's family and called the physician. They were not informed by the second RPN who had worked the previous shift that the resident had experienced pain and swelling on their shift.

During two separate interviews, the second RPN provided false information and denied awareness regarding the resident's injury, which misguided the interdisciplinary team, the home's investigation of the incident and prolonged the resident's discomfort. The inspector reviewed the home's video footage of the resident's interactions with staff the day the injury was discovered. It was noted that the second RPN assessed the resident during their shift and provided them with pain medication which was not signed for in the medication administration records.

The primary PSW verified that they provided personal care for the resident and they had informed the second RPN that resident appeared to have an injury, then brought the resident to the nursing station to be examined by the RPN.

The resident's SDM was onsite and also confirmed that they heard the resident express discomfort when the second RPN was providing care to the resident, however the nurse did not acknowledge the resident's discomfort.

The second RPN did not document their assessment of the resident, did not follow up related to their injury, did not report the injury to the physician; did not document the administration of medication, did not conduct a pain assessment, nor notify the resident's SDM that they had a possible injury.
On a later date, the resident was sent to hospital related to their ongoing pain, and they were diagnosed with a injury.

The DOC completed an investigation; however the investigation was unfounded since they were provided false information by the second RPN and they were unaware of the evidence shown in the video footage until it was discovered during the inspection. The DOC reported that the registered staff resigned from the home, and the incident was reported to the ministry and to the College of Nurses of Ontario

since the RPN's inaction or pattern of inaction jeopardized the health, safety or well-being of the resident.

Sources: Home's investigation notes, emergency department record, resident's progress notes, EMAR, interviews with RPN, PSW and the DOC.

An order was made by taking the following factors into account:

Severity: There was actual harm to the resident since they were diagnosed with an injury.

Scope: The scope of this non-compliance was isolated since only one resident was affected.

Compliance History: The licensee continues to be in non-compliance with s. 19 (1) of the LTCHA, 2007, resulting in two previous compliance orders (CO) being issued: CO #001 was issued on March 16, 2020, (Inspection #2020_643111_0007) and complied on April 30, 2021; and CO #001 was issued on May 13, 2019 (Inspection #2019_578672_0001) and complied on October 1, 2019. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2021

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 13th day of October, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by MOSES NEELAM (762) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Central East Service Area Office