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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 4, 2021	2021_946111_0002	003564-21, 003770-21, 012621-21	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village of Taunton Mills
3800 Brock Street North Whitby ON L1R 3A5

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

LYNDA BROWN (111)

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): September 20 to 22, 2021.

There were two complaints and one critical incident completed concurrently during this inspection:
-one complaint and one CIS, both related to same alleged staff to resident improper care.
-one complaint related to medications.

During the course of the inspection, the inspector(s) spoke with Assistant General Manager (AGM), the Director of Nursing (DON), Registered Practical Nurse (RPN), Personal Care Attendants (PCAs), Personal Care Attendant Coordinator and Kineseologist.

During the course of the inspection, the inspector reviewed resident health records, home's investigations, and the home's Code of Conduct, Investigation Process for Suspected Abuse of a Resident n policy.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

The licensee has failed to ensure that resident #011, the SDM, if any, and the designate of the resident had been provided the opportunity to participate fully in the development and implementation of the plan of care related to changes in medications.

Resident #011 had been prescribed a medication since admission and on a specified date, the medication was discontinued. The physician’s order indicated two RPN's had processed the order and there was no documented evidence the SDM or designate was notified. The DON indicated the expectation of the nurse for any verbal physician orders received, was to inform the family and document this in the resident’s progress notes. Both RPN's confirmed this did not occur. Failing to inform the SDM or designate changes in medications leads to the family not being provided the opportunity to participate in the plan of care for resident #011.

Sources: electronic medication administration records, physician orders, progress notes for resident #011 and interview of staff. [s. 6. (5)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Administrator received a verbal complaint from the family of resident #012, alleging improper/incompetent care. There was no documented evidence in the resident's health record regarding the incident. The home's investigation confirmed that the resident had a change in condition while being toileted and the PSWs did not immediately notify the nurse. There was no detailed description of the incident that was to be documented on the resident's record that clearly described the incident, physical findings and treatment provided, as per the home's zero tolerance of abuse and neglect policy. The investigation did not include a full investigation of all witnesses into the incident, as there was no interview of the RPN who was working when the incident occurred, as per the home's abuse and neglect policy. The DON confirmed the investigation should have included the RPN to determine if they had been notified of the resident's change in condition and actions taken. Failing to comply with the home's zero tolerance of abuse and neglect policy can lead to an incomplete investigation and a lack of appropriate actions to be taken.

Sources: Code of Conduct, Investigation Process for Suspected Abuse of a Resident by Team Member, Volunteer or Visitor policy, progress notes and care plan of resident #012, home's investigation, and interview of staff. [20. (1)]

WN #3: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

The Assistant General Manager received a verbal complaint from the family of resident #012, alleging staff to resident improper care. The Administrator and DON both confirmed that the investigation was concluded on a specified date, determined to be unfounded and the Director was not made aware of the results of the investigation.

Sources:CIS, progress notes, care plan and transfer assessments of resident #012, home's investigation and interview of staff. [s. 23. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

The licensee has failed to ensure that resident #010 received the assistance required to be dressed appropriately.

Resident #001 was observed in a mobility aid in the hallway, dressed inappropriately. A PCA confirmed they had provided care to the resident, they were to offer the resident a choice between two appropriate outfits, as per the residents preferences. The PCA confirmed the resident was not dressed appropriately. Failing to appropriately dress a resident can lead to a loss of dignity.

Sources: observation of resident #001, review of care plan for resident #001 and interview of staff.[s. 40.]

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Issued on this 13th day of October, 2021

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

Original report signed by the inspector.